THE OCCUPATIONAL AND BIOPSYCHOSOCIAL WELL-BEING OF SPEECH AND LANGUAGE THERAPISTS PRACTISING CLINICALLY IN THE UNITED KINGDOM

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ABSTRACT

Previous research has identified psychological ill health in allied health professionals. Whilst studies in the USA, Australia and elsewhere in the world provide some insight into the health of speech and language therapists (SLTs) generally, less is known about the well-being of the UK workforce, or about the environments in which they currently work.

The present study therefore sought to address this gap by examining the occupational and biopsychosocial well-being of SLTs working clinically in the United Kingdom. A mixed methods design consisted of two consecutive phases. The first, nomothetic phase was a longitudinal survey, utilizing a questionnaire distributed at two time points, three months apart. The questionnaire captured the job characteristics of SLTs, and measured the biopsychosocial stressors that they experienced, as well as their occupational and general biopsychosocial health. At the first time point of phase one, there were 632 participants and at the second there were 295. The first phase yielded both quantitative and qualitative data. The second ideographic phase consisted of semi-structured interviews; interpretative phenomenological analysis was used to explore the views of 15 SLTs, who were drawn from the main sample.

Results revealed that a third of SLTs in the sample had high strain jobs, characterised by high demands and low support. While high or very high levels of job satisfaction was reported by two fifths of participants, one in two achieved caseness on the GHQ-28, suggesting increased susceptibility to psychological difficulties. Low control and low support were associated with low job satisfaction, while high demands and low support predicted poorer general biopsychosocial well-being. Those participants who were self-employed had higher job satisfaction, lower occupational stress, and better biopsychosocial well-being than those who were organizationally employed or held a mixture of both types of employment. Five themes were identified in the qualitative data: ‘being’ an SLT; the daily working life of an SLT; a lack of validation and feeling unsupported; feeling conflicted and lacking control; and looking after well-being – successes and challenges. This research reveals the views and insights of an under-investigated professional group. The implications of the findings for SLTs working in the UK are discussed.

DEDICATION

This thesis is dedicated jointly to my late husband and to my daughter.

In memory of Matt who was always there for me. I miss you every single day and love you still.

And to Georgie, you are a hero. I love you squashie.

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PREFACE

I am a speech and language therapist (SLT). This thesis concerns an area that, during the twenty-five years that I have been practising, emerged very early on and continued to form an underlying worry for me – namely, the well-being of the SLT workforce. A description of a particular experience will go some way to explain the context out of which this project arose.

In early 2003, I was working for a busy inner-city NHS Trust, as a mainstream school SLT. My caseload, of just over 300 children, was spread over a number of schools, and direct contact with the children took place during term time only. Each school received support for one term in three – the smallest schools received a morning a week, with the largest schools receiving up to two days per week. The itinerant nature of this work meant that I did not see my SLT colleagues frequently, nor did I feel part of a team in any of the schools, where I essentially had the role of a visitor who was expected – at that time – to withdraw children on a 1:1 basis for their support. Due to the busy nature of the teachers' jobs, interaction with school staff was limited. I recall feeling very lonely in my job.

I clearly remember the day that I chose to leave my job. It was late afternoon and I'd been at a large primary school in the city, reviewing the speech, language and communication skills of some of the children on the caseload. I felt exhausted, although this wasn't anything new. I still needed to score the assessments I'd conducted, generate aims for intervention and write some reports for teachers. I was working systematically through my 'to do' list when I suddenly realised that I didn't care. Perhaps I should repeat that. I didn't care. It was a real 'road to Damascus' moment for me – I was horrified. Here I was, in a job that I had felt passionately about, a job that is described as a 'caring profession', and I didn't care. I was methodically 'getting through' everything that I was required to do, ticking boxes so that the service delivery requirements imposed by the trust could be met, without feeling that I was accomplishing anything worthwhile for the children on my caseload. It was at that point that I began looking for a non-clinical job and by September of that year I was working for a university, in a teaching role.

It was only when I began to read the literature on burnout almost fifteen years later that I came to understand that my tiredness, my feelings of not achieving anything of value, my growing detachment from service users, and the fact that I'd stopped caring in 2003 were

hallmarks of the elements of burnout - emotional exhaustion, depersonalization and reduced personal accomplishment. And that my despair at repeatedly absorbing the distress of parents, carers and professionals working with the children on my caseload – and not being able to really offer any help – was, in essence, 'compassion fatigue'.

I have discovered that I am not alone. Conversations with other SLTs, whether they work for the NHS or for other employers, whether they are employed or self-employed, raise feelings that I recognise. People say that they love what they do. They are passionate about supporting children and adults that have speech, language, communication and swallowing needs. They are also tired, stressed and anxious about their jobs, and many express doubts about their ability to carry on long term. My personal experiences, together with this anecdotal evidence of a possible problem within the workforce, has led me to this study. This thesis therefore investigates the occupational and general biopsychosocial well-being of speech and language therapists in the UK.

Dissemination of results has begun. The research presented initial results at the RCSLT Conference 2019: Improving Quality in Speech and Language Therapy. Following that, various SLTs contacted the researcher, asking to share the study results with their clinical teams. The researcher was also invited to speak at the RCSLT East Midlands Hub (November 2019) and the ASLTIP West Midlands Local Group study day (February 2020). She was invited to write a piece which appeared on the RCSLT website in March 2020, and was also interviewed to take part in a RCSLT podcast, which went live in March 2020. A research paper, authored by the researcher, appeared in the International Journal of Speech and Language Pathology in May 2020. In February 2021, ResearchGate listed 433 'reads' of the paper (197 full-text reads and 236 abstract reads). Twitter has also been a useful avenue for dissemination, with various tweets about the study results by the researcher being retweeted. Finally, the researcher has contributed to the working party established by the RCSLT after the onset of COVID-19, which investigates the well-being of SLTs.

CHAPTER ONE: INTRODUCTION

This study investigates the occupational and general biopsychosocial well-being of speech and language therapists (SLTs) working clinically in the United Kingdom (UK).

1.1 Overview of the chapter

The chapter commences with a description of the role of SLTs. Next, an outline of how health and well-being are conceptualized in the twenty-first century, and a conceptual framework of biopsychosocial well-being, are provided. A description of occupational well-being, construed as job satisfaction, is provided; and employment features that are necessary for work to contribute positively to people's health are described. The occupational causes of ill health are discussed, with a focus on mental health and well-being. In addition, the role of dispositional traits in work and well-being is considered. A model of occupational stress is examined, namely the Job Demand Control (Support) model (Johnson & Hall, 1988; Karasek, 1979). Information is provided regarding the cost to the nation of ill health and the occupational psychosocial well-being of public sector workers is described, with a focus on health professionals generally and SLTs specifically. Finally, the aims and objectives of the study are presented and the structure of the remainder of the thesis is outlined.

1.2 The role of speech and language therapists

Professionals supporting the development of speech, language and communication skills, as well as eating and drinking skills, are known in the UK as speech and language therapists. This professional group is identified across the world by various other titles, including 'speech-language pathologists' and 'speech pathologists and audiologists'. For the purpose of this thesis, the term 'speech and language therapists' (SLTs) will be used. SLTs identify, assess and treat speech (pronunciation), language, communication, interaction and/or eating, drinking and swallowing difficulties in both children and adults. All SLTs practising in the UK are required to be registered with the Health and Care Professions Council (HCPC), and to maintain their standards of proficiency. At the time this study was carried out, there were 15,932 SLTs registered with the HCPC (HCPC, 2017). The prerequisite for registration with the HCPC is successful completion of an approved degree, and there are currently 19 universities in the UK offering 26 pre-

registration courses. Full-time degrees are three to four years long, part-time courses are six years in duration, and there are some two-year postgraduate (pre-registration) programmes. Following the completion of an approved degree course, newly qualified practitioners (NQPs) are required to spend between 12 and 24 months under supervision, before being accepted as fully autonomous clinicians and being given certified Royal College of Speech and Language Therapists (RCSLT) membership. During this time, NQPs complete the *'Competency Framework to Guide Transition to Full RCSLT Membership'*. While it is compulsory to be a member of the HCPC (the regulatory body for the profession), registration with the professional body (the RCSLT) is voluntary. At the time of the project, 13,893 practising SLTs (87% of HCPC members) were RCSLT members (D. Munn, personal communication, 7 June 2017).

1.2.1 Employment landscape of speech and language therapists at the time of the study.

The landscape of speech and language therapy employment in the UK has changed significantly over the past decade. In 2009, Loan-Clarke, Arnold, Coombs, Bosley, & Martin stated that there was 'limited' scope for practising SLTs to be employed outside of public sector institutions, but that, with possible amendments to commissioning and service provision, this might change.

Of the 15,932 SLTs registered with the HCPC in 2017, many were working in the NHS. The distribution across the four home nations was as follows:

- 5932 whole time equivalent (WTE) SLTs in England (NHS Hospital & Community Health Service (HCHS) monthly workforce statistics, 2017)
- 969.4 WTE SLTs in Scotland (NHS Scotland Workforce Information, 2017)
- 516.8 WTE SLTs in Wales (StatsWales Non-medical NHS staff by grade and staff group, 2017)
- 445.3 WTE SLTs in Northern Ireland (A. McCullough, personal communication, 6 November 2017)

This total of 7,863.5 WTE SLTs in the UK is indicative of how not all registered clinicians work in the NHS, although accurate calculations of the proportion who do is not currently possible, because the HCPC registers individual therapists as 'bodies', who may work full time/part time and across numerous settings, while the NHS statistics reflect WTE posts.

This means that, in all likelihood, more than 7,863 therapists are employed in the health service. Nevertheless, while the NHS remains the dominant employer of SLTs, clinicians today are employed across a variety of settings. Increasing numbers of SLTs now work for employers other than the health service, for independent practices, and as sole practitioners. This is evident from a survey of practising clinicians carried out by the RCSLT in 2018 (n=1618) which revealed that 27% worked outside of the NHS (K Maietta, personal communication, 16.11.2018). Table 1.1 provides a breakdown of where SLTs were employed.

Table 1.1. Employment type of SLTs in 2018 (from the RCSLT member survey)

Employment type	Percentage of SLTs
National Health Service	73%
Independent practice – sole trader	7%
Independent practice – more than one SLT working	4%
Independent school/academy/free school	3%
Local Authority	3%
University or other higher education institution	3%
Not-for-profit organisation	2%
Social enterprise/public sector mutual	2%
Private health insurance	1%
Voluntary sector	1%
Justice	<0.5%
Social Care	<0.5%
Total number	**1618**

1.3 Well-being in the twenty-first century: The Biopsychosocial Model

The biopsychosocial (BPS) model (Engel, 1977) frames the way in which many professionals and laypeople view the health and well-being of the population in the twenty-first century (Marks, Murray, Evans, Willig, Woodall, & Sykes, 2005). Expanding on the previously accepted biomedical model, the BPS model facilitated the beginning of a paradigm shift towards a more holistic view of well-being. Included, in addition to the biological elements of health, were the psychological, social and behavioural contributions to well-being (Marks, et al., 2005). Based within general systems theory (Caltabiano Byrne,

Martin & Sarafino, 2002), the model acknowledged the individual as more than a body, but as a person. The recognition of the psychosocial elements of health facilitated the consideration of an expanded set of contributors to well-being e.g., the influence of stress on health, and the role of support in mitigating the harmful effects of stress. However, the inclusion of these elements in mainstream thinking around health also had the effect of complicating matters. The rise in non-specific symptoms (e.g., 'sick building syndrome', characterised by a range of symptoms, including headache, nausea, fatigue, dizziness, irritation of the skin, eyes, nose and throat, and reduced concentration and memory) meant that the association between ill health and exposure, and whether causality exists, became more difficult to identify and/or define. In addition, attitudes and belief systems, personality and locus of control are now recognized psychosocial aspects which influence illness, increasing complication (Spurgeon, Gompertz, & Harrington, 1997).

Nevertheless, the BPS model underpins much twenty-first century occupational health research, with investigators considering the physical and psychosocial aspects of both work environments and health outcomes. Examples of such research include studies by Bhardwaj and Srivastava (2008), Walker, Jackson, Egan and Thompson (2015) and Scaratti et al. (2018).

The next section considers well-being in the workplace, namely: occupational health.

1.4 Occupational health and the psychosocial workplace: the relationship between work and well-being

Occupational biopsychosocial well-being is domain-specific, focusing specifically on work and well-being. Occupational health (OH) pays attention to the two-way relationship between health and work, i.e., how the environment in which somebody works affects their health, as well as the effect that the health of an employee has on their ability to do their work. It is a multifaceted and multidisciplinary effort to ensure the well-being of populations that are employed (Aw, Gardiner, & Harrington, 2007). Contemporary conceptualization of OH adheres to the BPS model (Engel, 1977), including not only the physical, but also the psychological and social well-being of workers (Aw, et al., 2007). This biopsychosocial approach to well-being includes a subjective component, which contains both cognitive and affective evaluations made by individuals (Wright, Cropanzano, & Bonett, 2007). In the work-place, this subjective component of well-being can be described as job satisfaction (Wright & Cropanzano, 2000).

Job satisfaction can be measured as a global construct (i.e., addressing feelings about the job as a whole) or it can be scrutinized in terms of facets (Spector, 1997). Facet analysis refers to the investigation of satisfaction with different parts of the job e.g., pay or supervision. It is useful because people may feel differently about different aspects of their jobs, which may not necessarily be related to one another. It can therefore provide a more complete picture of someone's feelings and thus enable identification of possible areas for improvement in an organization (Spector, 1997).

In the UK, the "Review of the health of Britain's working age population: Working for a Healthier Tomorrow" (Black, 2008) specifically concentrated on OH and well-being. The report acknowledged the part that work plays in the health and well-being of the working population, with the assertion that the "quality of the experience that someone has in their workplace" (p57) can impact on health and well-being. There was recognition that organizations should view health and well-being more 'holistically', with reference to Engel's BPS model (1977), affirming that psychological and social factors impact on well-being. Finally, there was a recommendation that organisations provide health and well-being programmes and/or initiatives (Black, 2008). The response to the review was a Government publication entitled, "Improving health and work: changing lives" (UK Department for Work and Pensions, 2008), which stated a commitment to improving work and workplaces, and to supporting individuals to work. Specifically, the report pledged to institute new 'fit notes' to replace 'sick notes' and to review the health and well-being of the NHS workforce in particular.

A result of the assurance to review the well-being of the NHS workforce was the NHS constitution (2009), which pledged "to provide support and opportunities for staff to maintain their health, well-being and safety" (Department of Health, 2009, p10). This assertion was repeated in the 2017 update, with inclusion of specific measures that NHS Trusts should have in place to support well-being e.g. mindfulness programmes, resilience training, and the 'Steps 4 Wellness' programme, which included the promotion of both physical and mental health, as well as healthy lifestyles and social support (Balson, 2017).

Healthy workplaces were therefore viewed as environments that kept their employees not only physically safe, but free from psychological or mental harm too (Shain, 2004). Job design is an important aspect of this, and includes aspects such as autonomy/control, role

clarity, job content, workload, work schedule, and physical work demands (Vandenberg, Park, DeJoy, Wilson & Griffin-Blake, 2002).

1.4.1 A healthy workplace.

The Health and Safety Executive (HSE) – Britain's national regulator for workplace health and safety – provides some elucidation regarding the elements of a healthy workplace, which are detailed in their six Management Standards. The standards are described in relation to controlling the risks of work-related stress and adherence to them should result in good employment practice and simplify the risk assessment for some elements of work-related stress (Mackay, Cousins, Kelly, Lee, & McCaig, 2004). The six HSE Management Standards are:

- *Demands* (including, for example, the working environment, work patterns and workload)
- *Control* (how much say a person has in the way that they do their work)
- *Support* (including the provision of encouragement, sponsorship and resources by colleagues and line management): this scale can be transformed into two subscales – peer support and management support
- *Relationships at work* (including the promotion of positive working practices to avoid conflict; and dealing with unacceptable behaviour).
- *Role* (whether an organization ensures that a worker does not have conflicting roles and whether employees understand their role within an organization)
- *Change* (how organizational change – large or small – is managed and communicated in the organization)

1.4.2 Threats to occupational well-being: psychosocial hazards.

In order to manage the risks of work-related stress, identification of possible 'stressors' that threaten well-being require identification. These can be conceptualised as 'psychosocial hazards', a term that has been defined as 'any factor that may cause distress or psychological harm' (Smedley, Dick & Sadhra (2013, p134). Smedley et al.s' eight broad areas where factors could potentially cause psychosocial harm are similar to both the Sutherland and Cooper (1990) and the WHO (2002) categories. Table 1.2 amalgamates the categories of all three and lists components within those.

Table 1.2. Psychosocial hazards (or potential sources of stress)

Psychosocial Hazards	
Content of job **(factors intrinsic to the job*)*** *Work overload, deadlines*, difficulty of work, *time pressures*, under-loading (work too easy), safety critical work	**Organization of work (factors intrinsic to the job)** Shift work, long *working hours*, unsociable hours, unpredictable working hours, organizational restructuring, non-consulted changes, time-zone changes
Workplace culture **(organizational structure or climate)** Communication, little or no involvement in decision making (*participation*), feedback, resources, support, restrictions on behaviours (e.g., budgets etc.), office politics, lack of effective consultation	***Work role*** **(role-based stress)** Clarity of job, role ambiguity (having insufficient information to carry out responsibilities), role conflict (responsibilities conflict with the reality of daily professional life), conflict of interests and beliefs, lack of *control* over work, responsibility for lives, image of occupational role (*status*), boundary conflicts
Structure & *Career development* **(career development)** Over-promotion (self/others), under-promotion (self/others), redundancy threats (lack of job security), staff shortages, *pay* structure/ inequalities, thwarted ambition	***Relationships*** **(relationships with others)** Poor communication or relations with boss/subordinates/colleagues, social or physical isolation, difficulty delegating responsibility, harassment, bullying, verbal abuse, physical abuse/intimidation
Environment (factors intrinsic to the job) Noise, vibration, temperature, lighting, ventilation, humidity, hygiene, space, ergonomics, perceived hazard exposure	***Home-work interface*** **(home-work interface)** Childcare issues, transport problems, commuting, relocation, housing issues

Note. Based on the factors described by Smedley, Dick & Sadhra (2013), with the WHO (2002) labels in italics and Sutherland and Cooper's (1990) categories in brackets.

Conspicuously absent from the potential hazards listed in Table 1.2 is the psychosocial threat that is posed by expectations to cure, treat or support people who may have social, psychological or physical problems (Maslach, 1981). According to Maslach (1981), this threat is apparent in the 'helping professions' (p32) – social workers, doctors, psychologists, nurses, childcare staff, teachers and counsellors – members of which are expected to form intense and intimate relationships with service-users, often on a continuous, large-scale basis.

In an evaluation for the Department of Health (DOH), Harvey, Laird, Henderson, & Hotopf (2009), conducted a literature review of UK healthcare professionals, including speech and language therapists. They did not state how many papers were reviewed, only reporting that a wide selection of 'the most pertinent primary studies and any relevant review papers' (p15) was included. In addition, they interviewed fifteen 'key opinion formers' in occupational health for health care professionals. Finally, 21 regulatory bodies, unions and counselling services (41%RR) contributed to the study. The authors reported that routinely working with people who bring challenging and painful problems and needing to make decisions that have 'enormous' impact on the lives of service-users could be emotionally challenging and a source of stress. Examples of stressors were emotional demands when working with people, violence or aggression, dealing with illness and death, high public expectations, lack of understanding, patient demands, poor communication, bullying and harassment, fragmentation of teams, and overload resulting in conflict with home life. However, they also found that the way that work is structured and organised appeared to have 'considerable potential as risk factors for psychiatric disorder' (p7) which seemed to be more important than the emotional demands.

1.5 Stress: Definitions and models

Stress can be defined as "the particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p19). Psychological stress, however, is necessary for motivation, growth, development and change, so a certain level of stress can be good for us (Wilkinson, 2004). This beneficial stress is sometimes referred to as 'eustress' (Cooper, et al., 2001) and differs from 'distress', the emotional strain/tension that results from adverse, unwanted and unmanageable circumstances (Cooper et. al., 2001). These circumstances may result in frustration, tension, anger, anxiety, or depression, and can be damaging, affecting health and well-being (Wilkinson, 2004).

Work-related stress is a major challenge to occupational health (Marinaccio et al., 2013) occurring not necessarily only in the most extreme or dangerous professions, but in more ordinary workplaces too (Aw, et al., 2007). Since the 1960s, there has been recognition of the need to identify stress at work, as well as the causes of this stress, the consequences thereof and strategies to minimize stress (Bamford, 1995).

The WHO definition of work-related stress is 'the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope' (Leka, Griffiths, & Cox, 2004, p3). Although different people react differently to different situations and it might be argued that there is not a universal profile of what a stressful situation might be, it has been recognized that there are certain occupational conditions that are likely to produce stress in any individual (Karasek & Theorell, 1990).

1.5.1 A model of occupational stress.

The Job Demand Control (JDC) model (Karasek, 1979), has been used extensively throughout the world to frame research investigating the biopsychosocial work experience (Häusser, Mojzisch, Niesel & Shulz-Hardt., 2010; Van der Doef & Maes, 1999).

The model conceptualises psychological demand as workload – in essence, the answer to the question, 'How hard do you work?' Although there is acknowledgement that demand can be difficult to define (Karasek & Theorell, 1990), and that it includes notions such as role conflict and role ambiguity, the central component for most workers is workload (Karasek, 1979, Karasek & Theorell, 1990). Several authors have added to this conceptualisation e.g. Häusser and colleagues in 2010 operationalised 'demands' experienced by health workers as being specifically emotional in nature. Control comprises two areas, namely 'decision latitude' (autonomy) and 'skill discretion' – a variety of work tasks providing the opportunity to utilize different skills, and control over which specific skills to use to accomplish a task (Stansfeld & Candy, 2006).

The principal prediction of the original JDC model is that high psychological demands with low decision latitude will result in a 'high strain' job, which is associated with increased stress, decreased job satisfaction, and exhaustion and depression (Karasek, 1979). Further work with the model suggested that high strain jobs were also associated with physical outcomes such as an increased risk of cardiovascular disease due to higher blood pressure, difficulty with smoking cessation, and raised serum cholesterol (Karasek & Theorell, 1990).

In addition to the 'high strain' job, Karasek (1979) proposed three other possible outcomes of the demand-control relationship. Firstly, he posited that a combination of high demand *and* high decision latitude would result in an 'active job', where learning and motivation are

optimised, and job satisfaction is high. Secondly, jobs with low demand and low control would result in 'passive jobs' – associated with low satisfaction – and finally, those with low demands and high control would lead to 'low strain' jobs. The JDC model can be found in Figure 1.1.

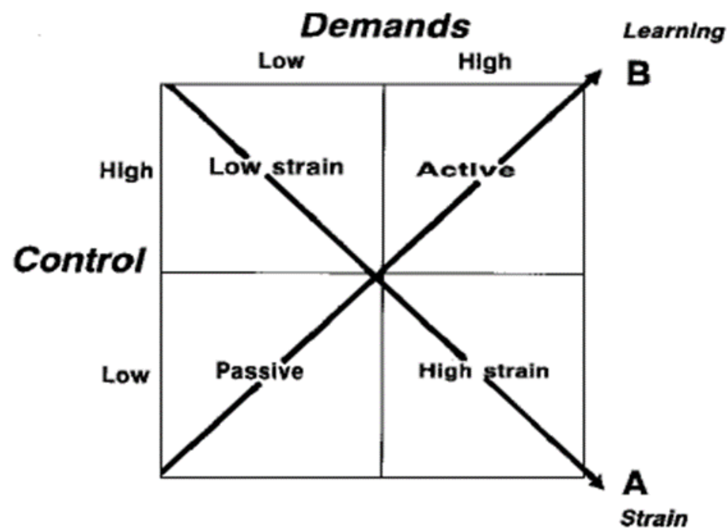

Figure 1.1. Job-demand-control model. Adapted from Karasek (1979)

The JDC model was further developed by Johnson and Hall in 1988, to include work-related social support; and the JDC model became the Job Demand Control Support (JDCS) model. Johnson and Hall initially described social support as informal interactions with co-workers, both at, and outside of, the workplace. This was later redefined to refer to overall levels of helpful social interaction available on a job from both co-workers and supervisors (Karasek &Theorell, 1990). The model therefore evolved to be three-dimensional, with support (or the lack thereof) serving either to buffer the impact of demands or to exacerbate those demands. Circumstances characterised by high strain and high isolation were labelled 'Iso-strain jobs'. In early descriptions, neither Johnson and Hall (1988) nor Karasek and Theorell (1990) included the support that individuals received from non-colleagues, i.e., from family, friends or community networks. The JDCS model is presented in Figure 1.2.

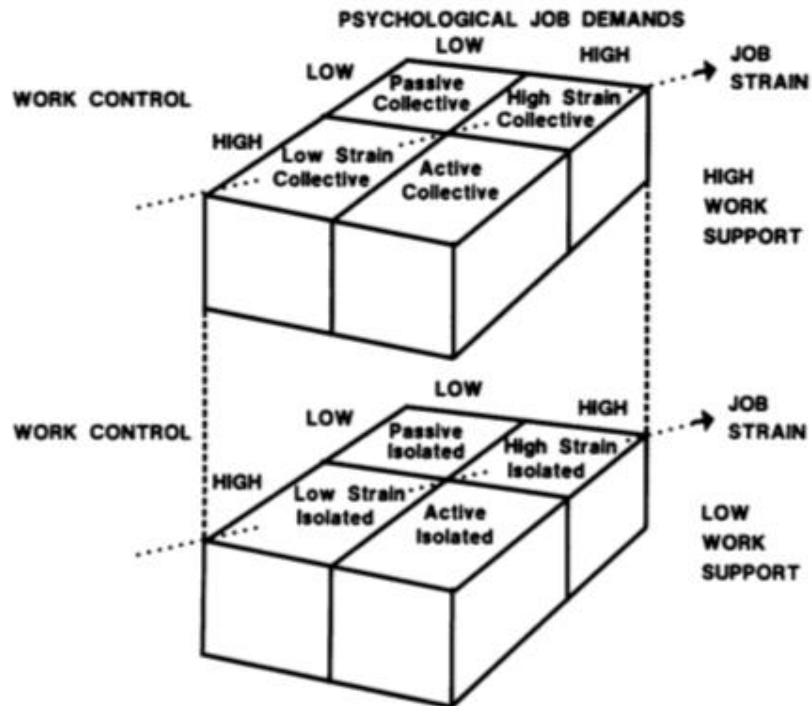

Figure 1.2. The Job Demand-Control-Support Model (Johnson & Hall, 1988)

Corroboration for the JDC/JDCS model has continued since its introduction and development. Two literature reviews (Van der Doef & Maes, 1999; Häusser, et al., 2010) have been published on the model, and have sought to summarise the findings of early research that aimed to verify the tenets of the model:

The first review, of 20 years of empirical research on the JDCS model and psychological well-being, was carried out by Van der Doef and Maes (1999). According to the authors, this review differed from those that had been carried out previously as those had focused on the model in relation to physical health outcomes. They found, however, that it was difficult to carry out a meta-analysis of research because different studies included different variables, meaning it was difficult to isolate the contribution of the JDCS model. They chose instead to conduct a systematic narrative review, the advantages of which were that they could include every empirical study conducted during the 20-year time period (*n*=63), thus giving a wider view of the field. They could also take into account methodological strengths and weaknesses when identifying the differences between those studies that supported the model and those that did not, whilst using an inductive approach to their analysis (Van der Doef & Maes, 1999).

The authors reported that the manner in which demand, support and control were conceptualised and how they were operationalised had an effect on whether studies confirmed the legitimacy of the model or not. Overall, there was considerable evidence for jobs with high demands and low control (the high strain hypothesis) resulting in the most negative psychological well-being, which included lower job satisfaction, more burnout and more psychological distress. There was also moderate support for the IsoStrain hypothesis, which states that jobs with the highest demand, lowest control and lowest support result in the worst psychological well-being. Further conclusions from the review were that there appeared to be general agreement regarding the additive effects of the model, but not for the interactive effects, and that evidence for the buffering effect of both control (in the JDC model) and support (in the JDCS model) was inconsistent. Finally, the negative impact of high strain and the buffering effect of control was *not* always in evidence when participants were women.

A follow up review in 2010, by Häusser, et al., scrutinized 83 studies that were published between 1998 and 2007. Again, the additive effects of demand, control and social support on psychological well-being was verified, providing sample sizes were sufficient – all studies with over 3000 participants revealed supportive results. Important was the identification, thanks to longitudinal studies, of a uni-directional causal relationship regarding the JDC(S) dimensions and *general* psychological well-being. However, with respect to *job-related* well-being (usually operationalised as job satisfaction), cross-sectional studies supported the principles of the JDC(S) model, but longitudinal studies did not, leading the authors to conclude that reciprocal causation might explain some of the correlations between control, demands, support and job satisfaction. Finally, evidence for the interactive effects predicted by the buffer effect was only found when demands were specifically operationalized for particular professions (i.e. were sample-specific), or matched with operationalized control and support factors e.g. operationalizing demand as work load or time pressure and control as scheduling or timing (Häusser et al., 2010).

Recent studies have found the central premise regarding high strain to be cogent when investigating well-being outcomes for health professionals. Examples of these studies include van Doorn, van Russeveldt, van Dam, Mistiaenn, and Nikolova (2016) who surveyed 210 nurses and reported higher emotional exhaustion for those who experienced high demand and low supervisor support; and Presseau et al., (2014) who reported that

the effects of high demand on distress were reduced by higher control for the 1,590 primary care staff that they surveyed.

While the JDCS model has been found to have universal significance, some authors have claimed that research on the JDC has been inconsistent, partly because different variables have been used to measure demands, control and support. Cognitive job demands and emotional job demands appear to operate differently in the prediction of psychological strain (Brough, et al., 2018), revealing that the type of job demand is important to consider when investigating an individual's well-being. In addition, individual characteristics of workers are often not included in studies, and not enough longitudinal research has been carried out (Kain & Jex, 2010). Kain and Jex recommend using longitudinal designs, the incorporation of both subjective and objective measures of strain, the inclusion of larger samples, and ensuring that types of demand and control match each other theoretically as much as possible.

The dimensions of demand, control and support that constitute the JDCS model form part of the HSE Management Standards, previously described.

1.6 The consequences of stress

Responses to stress, otherwise labelled 'strain' (Cooper, et. al., 2001) can be both short- and long-term. Immediate physiological responses to stress can occur in the short term, particularly to isolated (acute) stress events. These might include sympathetic nervous system reactions such as constriction of the cutaneous blood vessels, dilation of muscle blood vessels and secretion of sweat. In addition, adrenalin, noradrenalin and cortisol are produced. All this results in higher levels of arousal and increased heart rate, preparing the body for emergency (Lazarus, 1966, Sutherland & Cooper, 1990). In addition to these immediate responses to acute stress events, are the longer term physiological, psychological, and behavioural repercussions of chronic stress (Edwards, Webster, Van Laar, & Easton, 2008), and it is with these outcomes that this study was particularly concerned.

1.6.1 Physiological responses.

Physiological responses to stress might include headache, digestive disorders, musculoskeletal disorders, increased blood pressure, and heart disease (Cox & Jackson, 2005; World Health Organization, 2002). While this study did not investigate

musculoskeletal disorders or cardiovascular disease, for completion, more information on these two consequences of stress is presented in Appendix A1.

1.6.2 Psychological responses.

The psychological responses to stress are varied and may include cognitive or affective changes (Lazarus, 1966). Cognitive responses may include an inability to concentrate, and difficulty making decisions (Harvey, et al. 2009). Changes to affect may include irritability, less enjoyment of work, difficulty sleeping, fatigue/tiredness, and anxiety or depression (Fernandes & Da Rocha, 2009). There are associations between depression and sleep disturbance (Ryff, 1989) as well as anxiety and chronic fatigue (Crawford, MacCalman & Jackson, 2009). Furthermore, low morale, job dissatisfaction, and anger are all possible outcomes of psychosocial hazards (Vandenberg, et al., 2002; Smedley, et al., 2013).

1.6.2.1 Burnout.

Described as an extreme form of occupational stress, (Cooper et al., 2001), "burnout" is experienced particularly by those working in the helping professions (Maslach, 1981). It was characterised in 1996 by Maslach, Jackson and Leiter as including emotional exhaustion, depersonalisation and feelings of reduced personal accomplishment. This classification was updated by the WHO in 2018, to include 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) reduced professional efficacy. Particularly at risk of burnout are those who are required to work "intensely and intimately with people on a large-scale, continuous basis, (learning) about these people's psychological, social and/or physical problems, and are expected to provide aid or treatment of some kind" (Maslach, 1981, p31). Job dissatisfaction and job stress are both correlated with mental stress and with burnout (Cooper, et al., 2001, Hosseini, et al., 2016).

1.6.3 Behavioural responses.

The three main behavioural responses to stress are absenteeism, presenteeism and leaveism.

An increase in absenteeism, more staff turnover, and difficulties recruiting staff are all established consequences of stress (Leka, et al., 2004). Niedhammer, Chastang, Sultan-Taïeb, Vermeylen, and Parent-Thirion (2013) used data from the 2005 European Working Conditions Survey to investigate the relationship between various psychosocial factors at work, and absenteeism. Their sample consisted of 29,680 people from 31 countries in Europe, who were representative of those in employment (both employees and self-employed). They reported that high psychological demands, poor decision latitude, lack of social support, long working hours and job insecurity, were all risk factors for the incidence of sickness absence. In the UK, stress-related absence rose from 31% in 2016 to 37% in 2018 (Chartered Institute for Personnel Development [CIPD], 2018). The top cause for this stress-related absence was workload, with volume of work accounting for 60% of time off.

'Presenteeism' is defined "in terms of lost productivity that occurs when employees come to work ill and perform below par because of that" (Cooper & Dewe, 2008, p522); according to the Centre for Mental Health (2011) it is a more likely outcome than absenteeism. Harvey, et al. (2009) reported that presenteeism in the NHS was particularly high, possibly due to the organization and cultural climate that results in many healthcare workers being reluctant to take days off due to ill health.

'Leaveism', on the other hand, refers to the phenomenon of people using time outside of work, allocated time off, or sick leave, to work. (Hesketh & Cooper (2014). This behavioural response to stress, to which demand – in the form of workload – is a potential contributor, is evident within the UK workforce (Chartered Institute for Personnel Development, CIPD, 2018). The CIPD (2018), following their eighteenth annual survey examining trends in absence and health and well-being in UK workplaces, stated that over two-thirds of the 1021 organisations surveyed (representing 4.6 million employees) reported leaveism in their establishment over the preceding year. Of these, almost 60% stated that people worked outside of contracted hours to complete tasks, almost 40% stated that workers used annual leave when unwell, and a third reported that people used allocated time off (e.g., holiday time) to work. While this data is not specific to the NHS, public services (including education and health) were included in the sample.

1.7 Prevalence of work-related ill health in the UK

In the UK, based on self-reported data from the Labour Force Survey, the HSE provides annual reports on worked-related ill health. Musculoskeletal disorders (MSD) of the head, neck and upper limbs; and mental ill-health – including stress, depression and anxiety – were the two biggest causes of work-related ill health in 2018/2019 (HSE, 2019). Together, these two categories accounted for 81% of work-related ill health (see Figure 1.3).

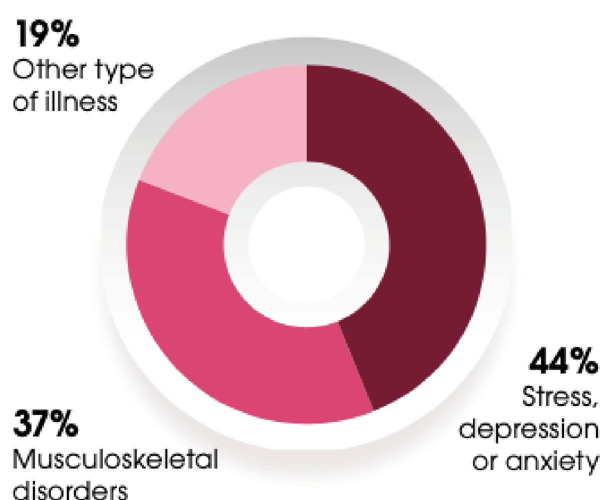

Figure 1.3. New and long-standing cases of work-related ill health by type (2018/19) From the HSE Work-related ill health and occupational disease in Great Britain summary (2019)

1.7.1 The cost of being unwell.

Much evidence suggests that healthy workers are productive workers and that the cost to the nation when the workforce is unwell, is significant (Black, 2008; Hartshorne, 2006; Cox & Jackson, 2005). As shown in Figure 1.4, the cost of sickness absence to the UK economy has been estimated to be around £16.2 billion per year (HSE, 2020). Figure 1.5 shows to whom these costs fall. Individuals bear the majority of the cost (£9.6 billion) followed by the government (£3.4 billion), and finally employers (£3.2 billion), (Black & Frost, 2011b; HSE, 2020).

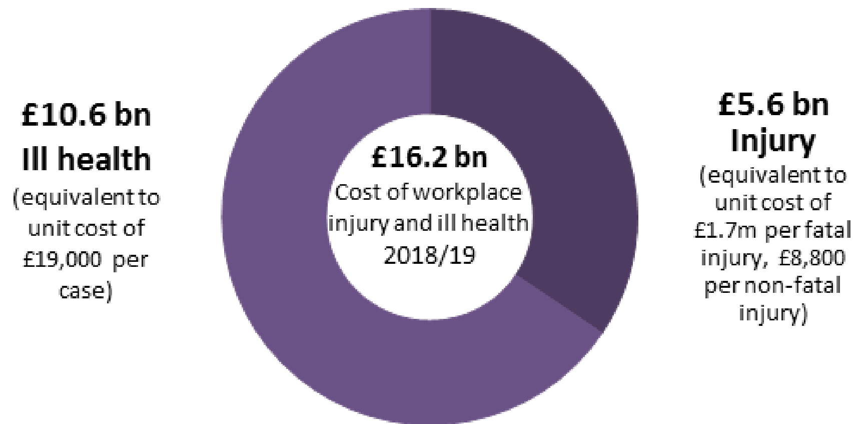

Figure 1.4. The cost of workplace self-reported ill-health and injury (HSE, 2020)

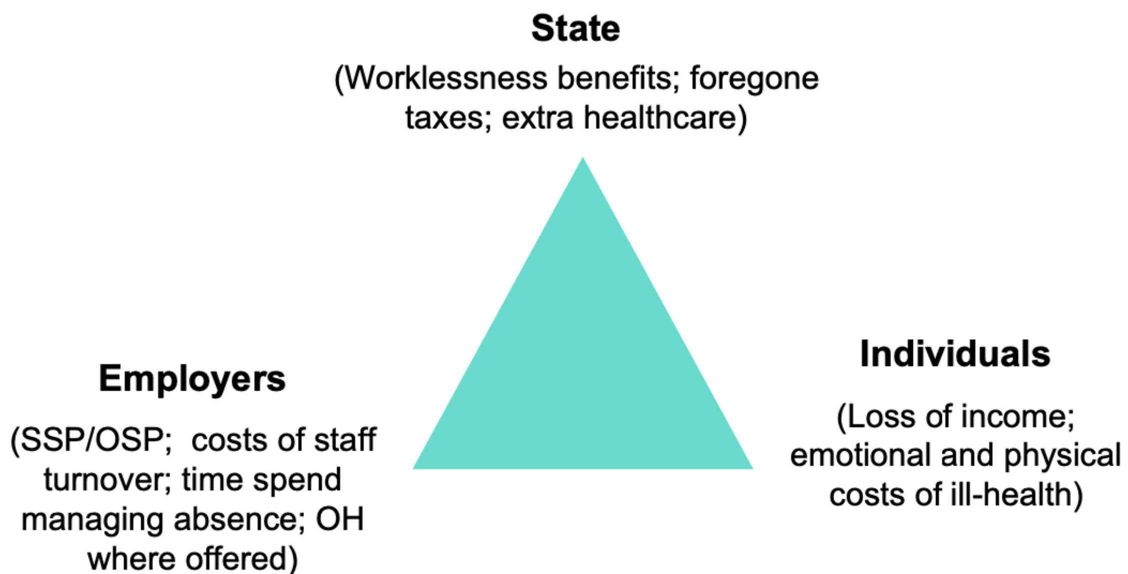

Figure 1.5 The cost of sickness absence to the individual, employer & state (Black & Frost, 2011b)

Key: SSP = statutory sick pay, OSP = occupational sick pay, OH = occupational health)

1.8 The role of dispositional traits in work and well-being

Since the latter part of the twentieth century, it has been widely accepted that a straightforward relationship between the work environment and well-being, in terms of psychosocial outcomes, is inaccurate (Sutherland & Cooper, 1990). Different people react differently to the same situations, and numerous individual differences, or dispositional traits, influence the stressor-strain relationship, which in turn has an effect on well-being (Cooper, et al., 2001). Trait theory is an approach to describing personality that suggests that patterns of thoughts, emotions and actions are enduring over time and stable across

situations (McCRae & Costa, 2008). A brief discussion of the evidence to support the importance of the role of dispositional traits in well-being follows.

1.8.1 The four core self-evaluations.

In 1998, Judge, Locke, Durham and Kluger described a set of four 'core self-evaluations', that they proposed were fundamental assessments that people make about themselves, that are stable and consistent, and that may explain the dispositional source of job satisfaction. According to Judge et al., the four core self-evaluations are 'fundamental' (i.e., underlying more surface traits), broad in scope, and evaluation focused. They are: self-esteem, generalised self-efficacy, locus of control and neuroticism. While trait theory holds that these evaluations will be stable and consistent (McCrae & Costa, 2008) further investigation, discussed in this section, into the relationships between work, well-being and the four traits, will suggest that they are susceptible to variation, depending on occupational experiences, and that they play a role in well-being.

1.8.1.1 Self-esteem.

Self-esteem can be described as the regard that a person has for themselves and refers to the value that an individual places on him- or herself – their self-acceptance, self-liking and self-respect (Judge, et al., 1998).

In a longitudinal study spanning 19 years, Donnellan, Kenny, Trzesniewski, Lucas and Conger (2012) applied trait-state statistical models to investigate whether self-esteem is primarily a fluctuating state or an enduring personality trait. They surveyed 451 participants (individuals recruited from Iowan state and private schools were followed from 13 to 32 years old) and found state factors accounted for 16% of the variance in repeated assessments of self-esteem, suggesting that context might have an effect on self-esteem. The authors acknowledged that their biennial surveys might not have identified short-term fluctuations in self-esteem (e.g., had they administered their questionnaire monthly). It is therefore possible that the contribution of more short-term psychological states to self-esteem were missed. In addition, the study used self-report, different findings could have resulted from informant reports.

Being in work has been correlated with improved self-esteem (Nakao, 2010; Waddell & Burton, 2006) and a certain amount of job demand can boost self-esteem (Stansfeld & Candy, 2006) which can in turn predict job satisfaction (Lange, 2012). Self-esteem may

therefore be susceptible to changes in the work environment (Xanthopoulou, Bakker, Demerouti, and Schaufeli, 2007). Self-esteem may also contribute to well-being. Edwards and Burnard (2003), reviewed 77 studies that reported stress and stress management interventions for mental health nurses between 1966 and 2000. They reported that self-esteem can predict well-being, and that self-esteem is probably one of the most important moderators of the effects of external stressors on well-being. However, although broad inclusion criteria allowed for the reporting of a high number of studies, this meant that methodological flaws detracted from the rigour of many of the studies. Kabakleh et al., (2021) reported that higher self-esteem was associated with lower emotional exhaustion and lower levels of depersonalization in the 487 nurses that they surveyed. The role of self-esteem in the relationship between workload and well-being has also been investigated. Del Mar Molero, del Carmen Pérez-Fuentes and Gázquez (2018) surveyed 1307 nurses aged 22 to 60 and reported that self-esteem mediated the relationship between workload (the number of service-users that a nurse treated during a workday) and burnout.

The above studies suggest that self-esteem may be vulnerable to change brought about by occupational stressors, and that it could predict occupational well-being, as well as possibly affecting the relationship between work and well-being.

1.8.1.2 Generalised self-efficacy.

The concept of self-efficacy was developed by Bandura (1997). It is a person's view that they are competent in relation to current demands faced (Warr, 2011). While this view is task orientated, Judge et al. (1998) have defined *generalised* self-efficacy as a person's appraisals of their "capabilities to mobilize the motivation, cognitive resources, and courses of action needed to exercise general control over many or key events in their lives" (p162). They therefore include it in their core self-evaluations, as it goes beyond beliefs regarding competency around domain specific tasks.

Self-efficacy, a self-regulatory need, can be a beneficial effect of employment where effort and reward are in balance (Siegrist, 1996). It has also been found to predict job satisfaction and psychological well-being (Machmud, 2018; Moeini, et al., 2008; Siddiqui, 2015; Tavousi, 2015). Finally, self-efficacy has been shown to mediate the relationship between workload and burnout (del Mar Molero, 2018). Suggestions are therefore that self-efficacy could be malleable, fluctuating in response to occupational elements,

contributing to well-being, and possibly explaining the relationship between work and well-being.

1.8.1.3 Locus of control (LOC).

The extent to which people believe that they have control over events in their lives can be explained in term of locus of control (LOC), a concept which Rotter introduced in 1954 (Halpert & Hill, 2011). According to Rotter (1996), those with a stronger internal LOC tend to believe that they can influence rewards and control their own destiny. They also tend to be happier, less stressed, and less depressed. On the other hand, those with an external LOC feel that outside forces are responsible for rewards that they experience. Rewards are attributed to luck, chance, fate or the influence of powerful others (Rotter, 1966). Although LOC and self-efficacy are theoretically related, there are differences between the two constructs. Self-efficacy is related to beliefs about actions and behaviours (competency and ability to mobilize personal resources) whereas LOC is concerned with outcomes i.e. the ability to influence a desired end-point (Judge et al., 1998).

LOC is not viewed as a stable trait by some. Wisniewski and Gargiulo (1997), reviewed the literature on occupational stress and burnout among special educators, and reported that, depending on whether professional interactions about a potential change (e.g., to an institutional policy or to classroom objectives) were successful or not, perceived personal control was either fostered, strengthened and developed; or conversely, eroded. The authors did not include their inclusion/exclusion criteria for the papers in their review, nor did they report the final number of papers reviewed or the period over which the review took place. Regarding the relationship between LOC and well-being at work, people with higher internal LOC have been found to have more job satisfaction and lower occupational stress (Kirkcaldy & Martin, 2000), while those with a higher external LOC have been found to have lower levels of job satisfaction (Bond & Bunce, 2003). Olonade, Ajibola, Oyewumi, Olusesi, and Bamidele (2020) surveyed 400 randomly sampled primary and secondary school teachers and reported a significant relationship between LOC and job satisfaction and that LOC significantly predicted employee’s job stress. Finally, LOC has been found to affect the relationship between work and well-being. It was reported to have a significant moderating effect on the relationship between job demand and job satisfaction in the 427 registered nurses surveyed by Bani-Hani and Hamdan-Mansour (2021).

In summary, LOC has been viewed both as resulting from the psychosocial features of work, as contributing to occupational well-being, and as possibly influencing the relationship between work and well-being.

1.8.1.4 Neuroticism.

Neuroticism is a dispositional trait that is characterised by anxiety, self-consciousness, vulnerability, hostility, impulsiveness and depression (Costa & McCrae, 1988). It is sometimes viewed as the negative pole of self-esteem, (Judge, et al., 1998) and is closely related to negative affect (Burns, Anstey, & Windsor, 2011). While Costa and McCrae (1988) report that neuroticism is a fairly stable personality trait, Cox & Jackson (2005), found that an adverse effect of shift-working was increased neuroticism, implying that job characteristics can impact neuroticism. Increased stress can also result in increased neuroticism (Deary, Watson, & Hogston, 2003), demonstrating that neuroticism can be viewed as a stress effect (Galvin, 2016). Because neuroticism is a strong predictor of negative affect (Judge et al., 1998; Williams, 2014), negative affect is often used as a measure of neuroticism (Judge et al., 1998). Negative affect has been negatively correlated with job satisfaction (Connolly & Viswesvaran, 2000), suggesting a further dispositional source of occupational well-being.

In summary, it would appear that the four traits included in Judge et al.'s core self-evaluations (1998) are at least partly vulnerable to change. They may also contribute to occupational well-being and should therefore not be ignored when investigating the relationship between occupational stressors and psychosocial well-being.

1.8.1.5 Optimism.

Dispositional optimism has been defined as 'a relatively stable, generalized expectation that good outcomes will occur across important life domains' (Wrosch & Scheier, 2003, p62). Studies have shown it to be related to well-being. For example, Barkhuizen, Rothmann and van de Vijver (2014) surveyed 595 academics from universities across South Africa and found that exhaustion and cynicism were negatively related to optimism, which also had a strong direct effect on the perception of job resources (supervisor relations, task characteristics & role clarity). Mäkikangas and Kinnunen (2003) surveyed 457 Finnish employees to investigate the effect that self-esteem and optimism had on the relationship between psychosocial work stressors (time pressures, lack of control, job insecurity, poor organizational climate) and well-being (job satisfaction, emotional

exhaustion, mental distress, physical symptoms). They reported that both optimism and self-esteem were important personal resources that had both main effects as well as moderator effects on well-being. Furthermore, optimism was found to strengthen the positive effect that autonomy had on job satisfaction by Montesa, Rodriguez and Marco (2019), who surveyed 1,647 employees in Spanish organizations.

1.8.2 The consideration of dispositional traits in the current study.

In this investigation of the relationship between the psychosocial properties of a job and an individual's well-being; self-esteem, generalised self-efficacy, locus of control, optimism and neuroticism (or negative affect) will be viewed as potential mediators in the relationship between the psychosocial work environment and occupational well-being (job satisfaction).

1.9 The occupational psychosocial well-being of workers in the health and education sectors in the UK

Investigating self-reported rates of stress, depression or anxiety in the general working population, the HSE (2018) reported a rate of 2,090 cases per 100,000 in the 'professional' category, a statistically significantly higher rate than the average across all occupations. Within this group, jobs across the public sector such as teaching (3,020/100,000) and healthcare (2,760/100,000) showed higher levels of work-related stress, anxiety or depression than the average (HSE, 2018).

1.9.1 An introduction to the occupational psychosocial well-being of speech and language therapists in the UK.

All SLTs working in the UK must be registered with the HCPC. The HCPC defines 'fitness to practice' as professionals having "the skills, knowledge, character and health they need to practise their profession safely and effectively" (HCPC Standards of Conduct, performance and Ethics, 2016, p13). Professionals are further tasked with managing risk within their roles, part of which is managing their own health. The HCPC Standards of Conduct, Performance and Ethics (2016) go on to state, "You must make changes to how you practise, or stop practising, if your physical or mental health may affect your performance or judgement or put others at risk for any other reason" (p10). The mental health of SLTs therefore forms part of their ability to do their jobs effectively.

There is a small body of UK research that reports SLT well-being – between 1980 and 2018 seven studies were sourced that discuss job satisfaction and/or stress. Three of these appeared in trade magazines, and only one of the peer-reviewed studies (Tatham, Clough & Maxwell, 1989) specifically investigated stress and its causes in one regional health authority. The research in the UK has focused on those therapists employed in the NHS, with a specific interest in the recruitment and retention of clinicians. Much of the research is dated but brings a historical perspective to the current picture. A brief description of this historical perspective will now be provided, as an introduction to the more recent literature analysed in chapter two, and to illustrate the need for the current study.

Two surveys in the 1980s revealed that stress in SLTs working in the NHS was widespread (Van der Gaag, 1988), and that causes of stress included large caseloads, lack of time, needing to work after hours to complete tasks and a lack of rewards (Tatham, Clough, & Maxwell, 1989). In addition, a third survey in the 1980s reported that a lack of job satisfaction resulted in clinicians leaving the service (Ware, 1988). Research in the next decade broadly supported findings of those studies. Eighty-two percent of therapists (occupational therapists, physiotherapist and SLTs) surveyed by Kersner and Stone (1991) reported symptoms of stress including aches and pains, forgetfulness, irritability and fatigue, and in 1995, one of the reasons that speech and language therapists were leaving the NHS was once again reported to be stress (Bebbington, 1995). The next two UK studies discussing stress and job satisfaction were published over a decade later (Cocks & Cruice, 2010; Loan-Clarke, 2009) – these two form part of the review in chapter two.

One study (Bebbington, 1995) sourced RCSLT-registered participants, which meant that SLTs working in sectors other than the NHS were represented. The author reported that 88% of participants were employed in the NHS, 3% in education, 1% in the independent sector, and the remainder in research/working abroad/non-practising. However, findings were reported for all respondents as one group, meaning any differences resulting from being employed in different sectors was not discussed. Schonfeld and Mazzola (2015) found that there are particular stressors for individuals who are self-employed in solo businesses, warranting closer examination of SLTs who are working in this way.

1.10 The current investigation and research aim

A preliminary review of the literature investigating the well-being of SLTs in the UK revealed a paucity of peer-reviewed studies – at the time of writing there were only two within the last 20 years (Loan-Clarke, et al., 2009, & Cocks & Cruice, 2010). The majority of studies are dated and do not account for the varied employment sectors within which SLTs currently work.

The aim of this project was therefore to:
Examine the occupational and general biopsychosocial well-being of SLTs currently working in the United Kingdom.

To meet the aim of the project, the following research questions were set:

Research question 1: What is the occupational well-being of SLTs currently working clinically in the UK?

Research question 2: What is the general biopsychosocial well-being of SLTs in the UK?

1.11 Structure of the thesis

This thesis comprises eleven chapters. The opening chapter provided a description of the role of SLTs and outlined how well-being is conceptualized in the twenty-first century. It discussed occupational health specifically, including healthy workplaces and the risks to well-being posed by psychosocial threats. Particular attention was paid to stress, a model of occupational stress was examined, and the consequences of stress were outlined. The role of dispositional traits in work and well-being was considered. Finally, an introduction to the occupational health of SLTs was provided, and the aims of the study were stated.

Chapter two reviews past literature that has reported the well-being of SLTs. An argument is made for the investigation of SLTs as a discrete professional group rather than as part of the allied health professional grouping. This is followed by an exploration of the literature pertinent to the study. The review focuses on papers reporting job satisfaction, stress and burnout in the SLT workforce. A synthesis of current knowledge regarding the occupational well-being of SLTs and the psychosocial work environment that contributes to SLT well-

being, is produced. The chapter underscores the rationale for the study and provides further detail, in the form of objectives, for the research questions.

The third chapter describes the methodology for the project. It details the mixed methods approach taken to answer the research questions and meet the set objectives. The philosophical assumptions that underpin the study are described, followed by the theoretical foundations and the research design. The rationale for the selection of a sequential explanatory mixed methods design, as well as the strengths and challenges of the approach, are explained. The remainder of the chapter describes the two phases of the project, providing details about the population, sampling, materials, procedures and data analysis for each phase.

Chapters four and five present the results from Phase One of the study, the longitudinal survey. First, the demographic composition and dispositional traits of the sample are described. This is followed by a depiction of the current working profiles of the participants, as well as their psychosocial work environments. Descriptive statistical data regarding well-being is presented, this details levels of job satisfaction, occupational stress and general biopsychosocial well-being. In addition, participants are grouped according to the JDCS model job types. Inferential data then explains the association between JDCS job types and occupational; as well as general psychosocial well-being. How elements of the psychosocial work environment predict both occupational and general psychosocial well-being is described. Mediation analysis provides information regarding the contribution of dispositional traits to the relationship between the psychosocial work environment and job satisfaction. A comparison between participants who are self-employed, those who are employed, and those who straddle both work sectors is made. Longitudinal data is used to explore the stability of occupational and general psychosocial well-being. Finally, qualitative analysis of participants' responses to an open-ended item is presented.

Chapters six, seven, eight, nine, and ten provide the results from Phase Two, the semi-structured interviews. A discussion of the five superordinate themes identified is provided. Using interpretative phenomenological analysis (IPA), attention is paid both to the individual's interpretation of their lived experience, as well as patterns within the data. Again, adhering to the principles of IPA, the researcher's interpretation of the participants' responses during the interviews is incorporated.

Chapter eleven presents the conclusions and implications of the study. The key quantitative and qualitative results from the previous chapters are integrated and discussed in detail with respect to the extant literature, and explanations for some findings are proposed. Recommendations for clinical practice, suggestions for future research, and the strengths and limitations of the project, are also presented.

CHAPTER TWO: A REVIEW OF THE EXTANT LITERATURE ON THE WELL-BEING OF SLTs

Part of this chapter is reproduced from:

Ewen, C., Jenkins, H., Jackson, C., Jutley-Neilson, J. & Galvin. J. (2020). Well-being, job satisfaction, stress and burnout in speech-language pathologists: A review. *International Journal of Speech-Language Pathology*, Early online, 1-11. https://doi.org/10.1080/17549507.2020.1758210

The full article is presented in Appendix B1.

2.1 Overview of the chapter

This chapter provides a review of the extant literature on the well-being of SLTs. It begins by placing SLTs within the broader occupational group termed 'allied health professionals.' A rationale for the consideration of the well-being of SLTs as a discrete professional workforce is provided. Following this, the aims of the review are outlined, along with the method used to conduct the review. The results of the review are presented, including a quality appraisal of studies and identified themes: job satisfaction, stress, burnout, and the factors that contribute to occupational well-being. Strengths and limitations of the review are also presented. The chapter concludes with a discussion of the results, incorporating methodological considerations. This provides further rationale for the research questions; and allows for the development of detail in the form of stated objectives.

2.2 Speech and Language Therapists as Allied Health Professionals

The term 'allied health professionals' (AHPs) is a recognised umbrella term for health care workers. Professionals included within the AHP group vary in research – some studies include psychologists (e.g., Gallego, Dew, Lincoln, Bundy, Veitch, Bulkeley, & Brentnall, 2015), others social workers (e.g., Wilson, 2015), dieticians, (e.g., Chisholm, Russell, & Humphreys, 2011), or radiographers (e.g., Coombs, Arnold, Loan-Clarke, Bosley & Martin, 2010). SLTs are oftentimes grouped with physiotherapists (PTs) and occupational therapists (OTs) (e.g., Bent, 1999; Bruschini, Carli & Burla, 2018). The value in treating the different professional groups as a unified whole might lie in the ability to increase the number of participants in a study and ultimately provide a voice for AHPs as a group; however, there are possible reasons to view the allied health professions separately, as demonstrated by three previous studies.

Smith-Randolph and Johnson (2005) surveyed 328 AHPs in the USA, utilizing an instrument designed to rate career satisfaction, the desire to remain in post and the importance of 45 different job aspects (e.g., competitive pay, flexible schedule, support by other healthcare professionals, realistic workload, direct patient care, feeling close to co-workers). Included in the sample were PTs (n=102), OTs (n=141) and SLTs (n=85). Employing regression analysis, the authors found that while PTs and OTs reported some factors in common that predicted their career satisfaction (e.g. professional growth and the environment being in line with their values), differences existed for all three professional groups. The OTs valued closeness with their co-workers, PTs rated team participation as important, and SLTs valued realistic workloads, flexible schedules and adequate support staff. The SLTs reportedly did not have any factors in common with the other two professional groups.

In addition to the above quantitative study, two qualitative studies lend support to the argument that AHPs should be viewed separately. Keane, Lincoln and Smith (2013) conducted focus groups with a range of Australian AHPs, including SLTs, to investigate retention of rural practitioners. The study did not separate data from the ten professions included. However, it was identified that, while recommendations to improve recruitment and retention are primarily based on research with medical professionals, there are differences between that group and AHPs, including management practices, CPD access, and resource allocation. This led the authors to conclude that 'health policy based on the assumption of transferability between professions may be misguided' (2013, p9). They also recommended further research to distinguish differences between single AHP data, as well as comparison of professions.

Finally, one longitudinal, qualitative study of the retention, turnover and return of AHPs in and to the National Health Service (NHS) in the UK (Loan-Clarke, Arnold, Coombs, Hartley, & Bosley, 2010) has been conducted. In that study, the participant sample at the first point in time comprised 1925 AHPs; including OTs (n=506), PTs (n=433), radiographers (n=456) and SLTs (n=530). At the second point in time there were 719 participants: OTs (n=204), PTs (n=144), radiographers (n=163), and SLTs (n=207). Content analysis was performed and data was reported for the group as a whole at each time point, with the authors stating that there was "no space to report figures for each of the professions [but that they] found that the responses across the four professions were very similar" (p395). However, a second paper from the same study (Loan-Clarke, Arnold,

Coombs, Bosley, & Martin, 2009), reported SLT responses only, but claimed that there were specific differences between the SLTs and other AHPs. Loan-Clarke et al. (2009) reported results of the content analysis for SLTs specifically, which revealed that 23% of them described excessive workload and pressure/stress. The authors stated that SLTs 'reported (this) more strongly than other professions...(and) placed greater emphasis than other professions on patient-related issues' (p893). In addition, 12% of those who had left the NHS commented on the lack of time spent with patients, this percentage was 'above the norm for the four profession in the study' (p893). In neither case were percentages for the other professions provided. Furthermore, unsatisfactory teamwork or collaborative working was reported by 11% of SLTs but 'not mentioned' (p894) by the other groups. Finally, the authors reported that the SLTs 'placed greater emphasis on the importance of appreciation and valuing of their profession than did the other professions in the study' (p895). Feeling 'personally undervalued/not respected' was reported by 8% of participants, but once more there was no data reported for other groups.

The above studies are suggestive of potential dissimilarities between the psychosocial work environments of SLTs and other AHPs, as well as possible differences in their occupational psychosocial well-being. Other potential differences between AHPs include the nature of the role – a critical variable in the work of an SLT is the therapeutic relationship between health care workers and service-users, which may not be the case for others e.g. radiographers. Further investigation of the reasons for occupational psychosocial well-being in SLTs as a discrete professional group was therefore warranted.

2.3 Aims of the Review

The review questions were:

1. Are SLTs satisfied with their jobs?
2. What levels of stress or burnout do SLTs experience in their jobs?
3. What are the work factors that are associated with SLT job satisfaction and stress/burnout?
4. What are the effects of job satisfaction and stress/burnout on recruitment and retention?

2.4 Method

2.4.1 Search Strategy.

Four electronic databases (PsycARTICLES & PsycINFO, PubMed/Medline, CINHAL and ABI/INFORM) were methodically searched for peer-reviewed articles published between 1998 and June 2018 and written in English. Search terms were categorised into two groups: (a) population, (b) occupational health. The first group included variants on the professional title of SLTs: “speech and language pathologist”, “speech pathologist”, “speech and language therapist”, and “speech therapist”. Because SLTs are sometimes included in studies that investigate allied health professionals (AHPs), key words also included the terms “allied health professionals” and “rehabilitation professionals”. The second group included terms used to describe the occupational health of workers: “well-being”, “job satisfaction”, “stress”, and “burnout”. Selection of the terms in this group was based on terminology that is commonly used within the field of occupational health to operationalise well-being at work. First, terms from the first group were entered using the Boolean operator OR e.g., “speech and language therapist” OR “speech and language pathologist; then the same procedure was used with terms from the second group e.g. “stress” OR “burnout”. Finally, the results from the first two searches were combined with the Boolean operator AND e.g., results of “speech and language therapist” OR “speech and language pathologist” AND results of “stress” OR “burnout”. Supplementary to this search strategy, the reference lists of articles located were used to source any additional, relevant articles.

2.4.2 Selection of Studies.

To be eligible for selection, the following criteria needed to be met: Papers were required to be empirical studies that reported primary research data that included information on either: 1) the well-being, job satisfaction, stress or burnout of SLTs, or 2) the well-being, job satisfaction, stress or burnout of AHPs where SLTs were included, mentioned explicitly in the analysis and reported on separately to other AHPs within the participant group. No restrictions were placed on study design, as this search aimed to be as inclusive as possible.

2.4.3 Quality Assessment.

The quality of papers presenting quantitative data was assessed using an adaptation of the “Strengthening the Reporting of Observational Studies in Epidemiology” (STROBE) recommendations (Vandenbroucke et al., 2014). Adaptation was necessary, because although the articles reviewed could be classified as epidemiological, the STROBE guidelines were developed for use in medical research. The quality and credibility of papers presenting qualitative data were assessed using the “Consolidated criteria for Reporting Qualitative research” (COREQ) checklist (Tong, Sainsbury & Craig, 2007). Mixed methods papers that produced both types of data were assessed under both sets of criteria.

2.4.4 Data analysis and evidence synthesis.

Disparate study designs and approaches to data analysis prevented the use of meta-analysis. To enable the synthesis of the findings of the search, a data-driven thematic analysis of findings was conducted (Dixon-Woods, Agarwal, Jones, Young & Sutton, 2005). The aim of this was to facilitate a fully inclusive review of findings. One author (CE) used open coding techniques to identify major themes.

Although “well-being” was entered as a search term, no studies explicitly included the construct as an outcome. The three remaining constructs (job satisfaction, stress and burnout) were analysed as follows: Firstly, the presence or absence and level of the construct reported was examined. Secondly, the factors associated with these concepts were classified into themes. Themes were included if they appeared in three or more studies.

2.5 Results

2.5.1 Studies included.

Of the seventeen papers that were sourced, eight studies took place in the USA, three were carried out in Australia and two in the UK. One study took place in Canada, one in Italy, one in Iran, and one in South Africa. A data extraction table (Appendix B2) provides descriptions of the study locations, populations, designs, area investigated, and measurement methods used.

Three study designs were present within the literature: thirteen consisted of cross-sectional surveys that yielded quantitative data. Two were mixed-methods studies, where qualitative and quantitative data was gathered as part of large-scale cross-sectional surveys. Of these, one paper (Loan-Clarke, Arnold, Coombs, Bosley & Martin, 2009) only reported their qualitative findings, which they then quantified (the quantitative element of the study was reported elsewhere and did not separate out SLTs). Finally, two used qualitative designs.

Participant numbers ranged from 23 to 1207 in the cross-sectional surveys (reported response rates ranged from 19.6% to 71.2%). One mixed methods study had 293 participants and the other had 516. Seven participants were interviewed in one of the qualitative studies, and 18 were interviewed in the other.

All studies included in the review reported the job satisfaction, stress/stressors, or burnout experienced by SLTs. These constructs were sometimes considered to be predictors of outcomes (e.g., job satisfaction predicting retention), and sometimes as outcomes (e.g. stress as the outcome of lack of support).

A variety of scales were used in the cross-sectional studies to measure job satisfaction, stress or burnout. Six of the fifteen studies that gathered quantitative data used questionnaires that were designed by the authors. The Speech-Language Pathologist Stress Inventory (SLPSI; Fimian, Lieberman, & Fastenau, 1991), the Job Satisfaction Survey (JSS, Spector, 1997), the Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985) and the Maslach Burnout Inventory (MBI, Maslach, Jackson & Leiter, 1996) were all used twice. In addition, five other published scales were used. Statistical analysis included inferential tests and structural equation modelling, some studies limited their analysis to descriptive statistics, and not all provided central tendency data. The two mixed methods studies used content analysis to explore open-ended items on their surveys, with one of these (Loan-Clarke et al, 2009) quantifying the data to perform frequency distribution analysis. One qualitative study identified themes within the data collected from interviews, which they then coded; the other used phenomenological analysis to interpret findings.

2.5.2 Literature search.

The search yielded 2050 papers. Duplicates (640) were removed, after which the titles and/or abstracts of the remaining 1410 articles were reviewed for relevance. This resulted in 25 studies being identified. The inclusion criteria were then applied to the full text of these studies, after which 15 papers remained. The main reason leading to the exclusion of full text articles was the failure to separate SLT data from the other AHPs in the study. One study was excluded because the investigation specifically reported satisfaction with elements particular to a location i.e. the structure and functioning of newly established Family Health Support Centres in Brazil (Molini-Avejonas, Aboboreira, Couto & Samelli, 2014). Two publications were added after reference checking, bringing the total number of papers reviewed to 17. The process for the inclusion of studies in the review can be found in Figure 2.1.

2.5.3 Quality appraisal.

The fifteen studies yielding quantitative data were assessed using the STROBE statements. Of these, twelve included sixteen or more of the possible twenty-two criteria. One contained thirteen criteria, one contained twelve, and one contained eleven criteria. The majority of the quantitative papers included the following methodological strengths: the study objectives, sources and methods of recruitment, variables under investigation and data sources/measurement were clearly described and appropriate. The methodological criteria least often included was bias, with only two studies discussing the attempt to deal with possible bias (in the measurement instruments). Only two studies included information about how the sample size was reached (funding restrictions) but none mentioned the determination of sample size with regard to statistical analysis (e.g. through power analysis), although one did state that the final numbers of participants was sufficient for sound statistical analysis. The reporting of results was variable, with descriptive statistics more commonly provided and fewer studies engaging in further analysis. Two papers provided effect sizes. The quality appraisal for the papers reporting quantitative data is presented in Table 2.1.

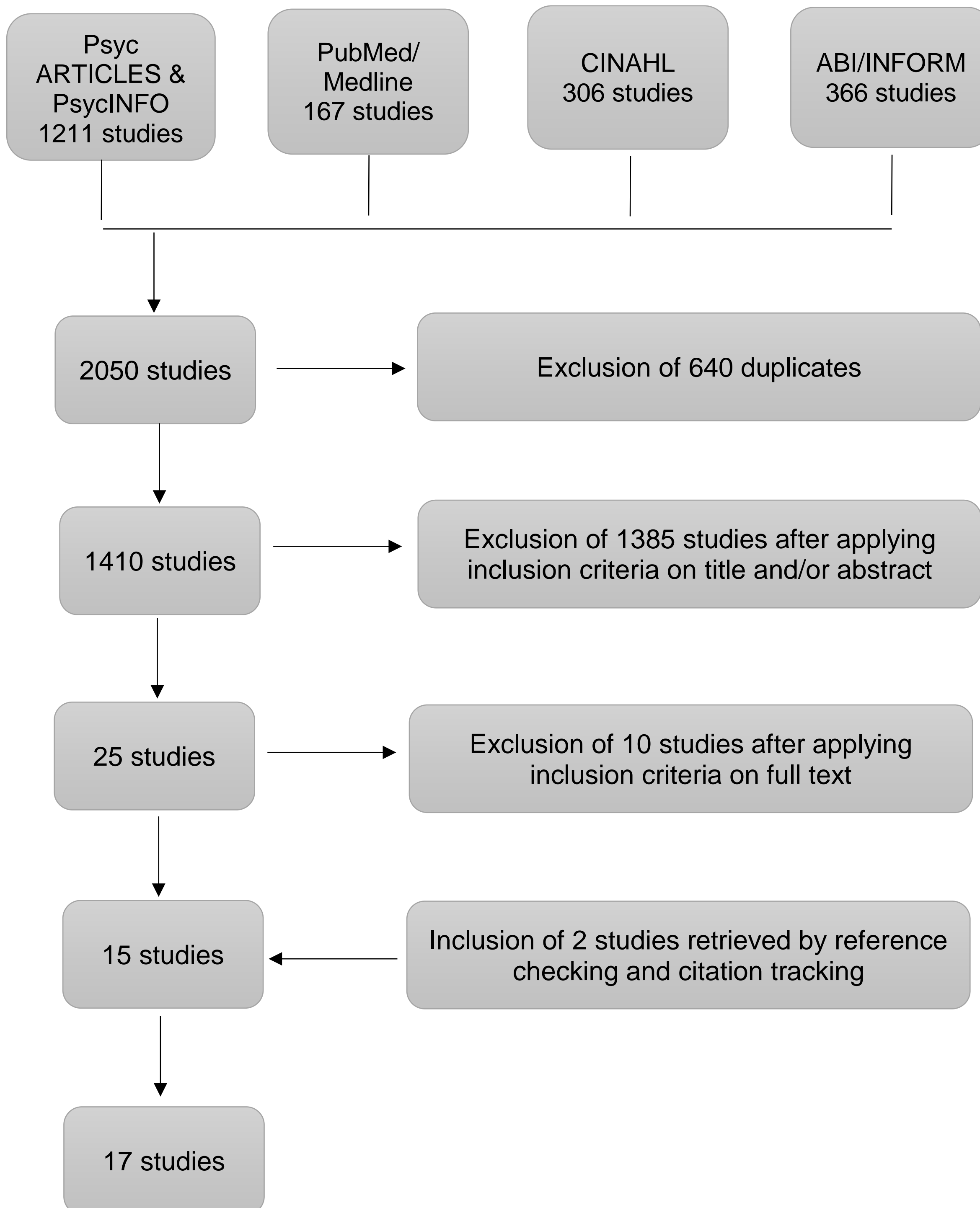

Figure 2.1. Flowchart of the inclusion process for articles reviewed

The four papers presenting qualitative data were assessed using the COREQ criteria. For the two qualitative studies which conducted interviews, one study met seventeen of the thirty-two criteria. Not all items were applicable to the second study, which met eleven of the thirty that were germane. For both, the protocol was provided, sampling methods were described, and themes were clearly presented and supported with quotations from

participants. Credibility was achieved for both papers through clear reporting of methods and consistency between data and results (Silverman, 2011). However, neither paper provided information about the research team and its reflexivity (although Warden, Mayers & Kathard, [2008] did include the gender and occupation of the interviewer), about how the final sample size was reached (e.g. whether the need for, or relevance of saturation was considered), or whether participant checking (i.e. participants providing feedback on findings) took place. Only one (Warden et al., 2008) stated the methodological orientation that underpinned the study. The two mixed methods papers that gathered qualitative data through large-scale surveys (Heritage, Quail & Cocks, 2018; Loan-Clarke, et al., 2009) did not lend themselves well to the COREQ criteria, with some items being irrelevant. Of the fourteen criteria that were relevant to both, nine were met in each case. Both presented themes clearly, but the Loan-Clarke et al. (2009) study provided only one example of a question asked and did not include participant quotations. This resulted in a lack of transparency regarding consistency between data and findings, meaning credibility was potentially threatened. The quality checklist for the four papers reporting qualitative results is presented in Table 2.2.

Table 2.1. Quality assessment of the papers presenting quantitative results (n=16)

Reference	Abstract & Title		Introduction		Method									Result				Discussion				Other info
	1a	1b	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Heritage et al. (2018)	+	+	+	+	+	-	+	+	+	+	-	+	+	+	-	-	+	+	+	+	+	+	-
Bruschini et al. (2018)	-	+	+	+	+/-	+	+/-	+	+	-	-	+	+	+/-	+	+	+	-	+	-	+	-	-
Kasbi et al. (2018)	-	+	+	-	+	+	+	+	+	-	-	+/-	+/-	-	+	+	+	-	+/-	+	+	-	+
Kaegi et al. (2002)	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+/-	+	+/-	+	+	+	+	+	-
Kalkhoff & Collins (2012)	+	+	+	+	+	+	+	+	+	-	-	+	+	+	+	+	+	+	+	+	+	+	-
Cocks & Cruice (2010)	+	-	+	+	+	+	+	+	+	-	-	+	+	-	+	+	+	-	+	+	+	+	-
Hutchins et al. (2010)	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+	+	+	-	+	+	+	+	-
McLaughlin et al. (2010)	-	+	+	+	+	+	+	+	+/-	-	+	+	+	+	+	+/-	+	+	+	+	+/-	-	-
Harris et al. (2009)	-	+	+	+	+	+	+	+	+	+	-	+	+	+	+	-	+	+	+	+	+	+	-
Edgar & Rosa-Lugo (2007)	+	+	+	+	-	+	+	+	+	-	-	+	+	+	+	+	+	+	+	+	+	-	-
Loan-Clarke et al. (2009)	+	+	+	+	+	+	+	+	+	-	+	+	+	+	-	+	-	-	+	-	+	-	+
Smith-Randolph & Johnson (2005)	+	+	+	+	+	-	+	+	+	-	-	-	+	-	+	+	-	+	+	+	+	+	+
Blood, et al. (2002a)	+	+	+	+	+	+	+	+	+	-	-	+	+	+	+	+	+	-	+	+	+	-	-
Blood, et al. (2002b)	+	+	+	+	+	+	+	+	+	-	-	+	+	+	+	+	+	-	+	+	+	+	-
Blood, et al. (2002c)	-	+	+	+	+	+	+	+	+	-	-	+	+	+	-	+	+	+	+	-	+	-	-

Source: Vandenbroucke, 2014

Note: 1a Study design mentioned in title/abstract 1b Balanced summary in abstract 2 Background/rationale included, 3 Objectives stated, 4 Key elements of study design, 5 Setting, 6 Participants (sources & methods of recruitment), 7 Variables described, 8 Data sources/measurement included, 9 Bias addressed, 10 Study size explained, 11 Quantitative variables (how handled), 12 Statistical methods described & appropriate, 13 Participant numbers & reason for ineligibility, 14 Demographics described, 15 Outcome data (numbers or summary), 16 Main results (e.g. correlations), 17 Other analyses (e.g. subgroups, testing of models), 18 Key results (in reference to objectives), 19 Limitations, 20 Interpretation, 21 Generalisability discussed, 22 Funding mentioned

+ reported - not reported +/- some elements present/appropriate

Table 2.2. Quality assessment of the papers presenting qualitative results (n=4)

	Research team & reflexivity								**Study design**															**Analysis & findings**								
	Personal characteristics					**Relationship with participants**			**Theoretical framework**	**Participant selection**				**Setting**			**Data collection**							**Data analysis**					**Reporting**			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Heritage et al., (2018)	*	*	*	*	*	*	*	*	+	+	+	+	*	**	**	-	*	*	*	*	*	*	*	+	-	+	-	-	+	+	+	+
Loan-Clarke et al. (2009)	*	*	*	*	*	*	*	*	+	+	+	+	*	**	**	+	*	*	*	*	*	*	*	+	-	+	+	-	-	-	+	-
McLaughlin, et al. (2008)	-	-	-	-	-	-	-	-	-	+	+	+	-	**	**	+	+	-	+	-	-	-	-	+	-	+	-	-	+	+	+	-
Warden, et al. (2008)	-	-	+	+	-	-	-	-	+	+	+	+	-	-	-	+	+	+	+	+	+	-	+	-	-	-	-	-	+	+	+	+

Source: Tong et al., 2007

Note: 1 interviewer identified, 2 credentials provided, 3 occupation, 4 male/female, 5 training/experience, 6 relationship established, 7 participant knowledge of researcher, 8 interviewer characteristics e.g. assumptions, 9 methodology, 10 sampling, 11 method of approach, 12 number of participants, 13 refusals/drop outs, 14 setting of data collection, 15 presence of non-participants, 16 characteristics of sample, 17 interview guide described, 18 repeat interviews? 19 audio/visual recording 20 field notes 21 duration 22 data saturation discussed, 23 transcripts returned? 24 number of data coders 25 description of coding tree 26 derivation of themes, 27 software, 28 participant checking, 29 quotations presented, 30 data and findings consistent, 31 clarity of major themes, 32 clarity of minor themes

+ reported
- not reported
* not applicable, as design was cross-sectional survey that gathered qualitative data
** not applicable, as data gathered over the phone or via questionnaire mailed to participants

2.6 Findings of the Review

2.6.1 Level of well-being.

Only one study reported well-being as a specific construct under investigation. Using A Shortened Stress Evaluation Tool (ASSET), McLaughlin, Adamson, Lincoln, Pallant and Cooper (2010) investigated well-being as a predictor of intent to leave a job or the profession. The ASSET psychological well-being mean score was not provided, meaning it is not possible to comment on the level of well-being for participants in their study. The remaining studies specifically investigated job satisfaction, stress (or stressors) and/or burnout. These terms were not used to operationalise well-being as a construct, although well-being was sometimes used as a general term in discussion sections.

2.6.2 Level of job satisfaction.

The level of job satisfaction in SLTs was reported in seven studies. Hutchins, Howard, Preclock and Belin (2010) reported "high degrees" of satisfaction, based on the overall mean of a self-designed questionnaire. Blood, Ridenour, Thomas, Dean-Qualls and Scheffner-Hammer (2002b) found that clinicians working in state schools in the USA had average job satisfaction scores on the JSS (i.e., mean score of 126.8 within one SD of the expected mean score of 136.5). The JSS was also used by Kalkhoff and Collins (2012), at which time SLTs in the USA scored significantly higher (M=147.3, SD=29.5) than the norm for the average American worker (M=136.5, SD=12.1) on overall job satisfaction. Moreover, 50 respondents (51%) in that study had high satisfaction (individual mean scores >1SD above the JSS mean) and 31 (32%) had average job satisfaction (individual mean score within one SD of the mean). A UK study by Cocks and Cruice (2010) reported that 27% of overseas-trained SLTs were satisfied with waiting lists, 30% with caseload size, 30% with status, and 52% with salary. Loan-Clarke et al. (2009) reported that 13% of their participants cited job satisfaction as a reason to remain working in the National Health Service (NHS) in the UK.

Edgar and Rosa-Lugo (2007) asked participants working in public schools in the USA to rate how strongly they "favoured" 24 different elements of their jobs. They concluded that the five areas which had the most satisfaction included working with children (74%), school schedule (54%), school hours (45%), school assignment (41%) and the availability of an

experienced mentor (41%). The four areas where most dissatisfaction was reported were overwhelming workloads (44%), the role of the SLT being misunderstood (41%), salary (40%), and large caseloads (35%).

Kaegi, Svitch, Chambers, Bakker and Schneider (2002) compared a sample of 56 clinicians working in Canada across three locations: rural Alberta (n=29), urban Alberta (n=18) and Ontario (n=9). There were significant differences in the length of time in the job across groups, with those who had worked longer (clinicians in Ontario) being less satisfied. The authors found that 66% of the clinicians working in rural Alberta, 72% of those employed in urban Alberta and 12% working in Ontario were satisfied with their jobs. Despite apparent differences between groups, when length of time worked was used as a covariate in analysis no significant differences in satisfaction were found between them.

2.6.3 Level of stress and burnout.

While burnout is specifically conceptualised using the three dimensions mentioned previously, and therefore might be viewed as a separate construct to stress, the World Health Organisation (2018) defines it as a ‘syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed’. Stress and burnout were therefore considered together. Three studies identified in the review investigated stress and three reported on burnout. Three studies reported the relationship between stress and behavioural responses in participants and one of the qualitative studies identified burnout in their themes.

Two of the three papers investigating stress (Blood et al., 2002c) compared stress levels of participants to an earlier study (Fimian et al., 1991). In each study, respondents completed the SLPSI, a measurement tool specifically designed to investigate the effect on stress levels of particular stressors for SLTs. Participants who completed the SLPSI in the 2002 study were reported as having “barely noticeable” stress when compared to the original 1991 sample. However, no statistical test to determine significance was reported. Harris et al. (2009) found that state school clinicians in Utah, who also completed the SLPSI, had significantly less stress than the original sample.

Blood, Blood, Scheffner-Hammer and Dean-Qualls (2002a), using the Health Profession Stress Inventory (HPSI), compared their findings to normative means for nurses (M=61.2),

pharmacists (M=56.0) and general physicians (M=46.9) and found that SLTs working in US healthcare had 'comparatively low' levels of stress (M=48.5). Once again, significance testing was not reported by the authors.

Burnout in Iranian SLTs was investigated by Kasbi et al. (2018). Of the 182 participants in the study, 99.7% reported some level of burnout (44% had mild burnout, 53.5% moderate burnout, and 2.2% severe burnout). Kaegi et al.'s 2002 questionnaire included the statement, "I suffer from burnout", to which 79 (51%) respondents agreed or strongly agreed. In a study of Italian AHPs, Bruschini, Carli and Burla (2018) found that 10% of SLTs were at risk of burnout. They defined 'burnout risk' as having high scores on the Emotional Exhaustion and Depersonalisation subscales of the MBI, and low scores on the Personal Accomplishment subscale. The AHP data (which included the SLTs) showed that 32% were experiencing high levels of emotional exhaustion, 13% depersonalisation and 9% reduced personal accomplishment. No statistically significant differences were found between the different groups of AHPs.

One qualitative study added to the literature on burnout. McLaughlin, Lincoln and Adamson (2008) identified feelings of decreased personal accomplishment (one element of burnout) in their interviewees, which led them to conclude that the SLTs were possibly at risk of developing burnout.

2.6.4 Job factors associated with job satisfaction, stress and burnout.

Studies explored a variety of factors that might contribute to job satisfaction or stress/burnout. Examples of findings include the achievement of a balance between work and home predicting job satisfaction (Smith-Randolph & Johnson, 2005), a lack of correlation between educational qualification and job satisfaction (Blood et al., 2002) and no relation between distance travelled to work and risk of burnout (Bruschini et al., 2018). However, the weight of evidence pointed toward workload/caseload (demand), control, support, work setting, and salary as important factors associated with the outcomes, with three or more studies reporting on these factors (although not always being reported as a specific objective of the study). These factors were therefore considered as themes for the purpose of structuring this section of the review.

2.6.4.1 Workload and/or caseload size.

Satisfaction with workload or caseload size was the most frequently cited factor, with thirteen of the papers including findings about this element of the job. In the USA, studies on the relationship between job satisfaction and workload and/or caseload size have described varied results. Blood, et al. (2002b) identified a significant negative correlation between caseload size and job satisfaction for SLTs. Smith-Randolph and Johnson (2005) found that a “realistic” workload was a predictor of job satisfaction and Edgar and Rosa-Lugo (2007) reported that 34.6% of their 382 participants were dissatisfied with caseload size and 44.2% were dissatisfied with workload.

Hutchins, et al. (2010) reported that while SLTs were generally satisfied with their jobs, there was a significant relationship between caseload size and workload satisfaction specifically. The perception of a high caseload was associated with increased stress in Harris et al.’s study in 2009; and Blood, et al., (2002c) described overwork and large caseloads as “chronic” stressors for school-based SLTs. However, Blood et al. (2002a) found no statistical relationship between caseload size and stress. Finally, Kalkhoff & Collins (2012) argued that job satisfaction was not predicted by caseload size but no statistical information to support this claim was provided.

Studies from countries outside of the US are not as plentiful. Kaegi et al. (2002) reported a negative association between caseload size and satisfaction in Canadian SLTs. In Cocks and Cruice’s (2010) study of overseas-trained clinicians working in the UK, 30% of their 23 participants reported larger UK caseload sizes compared to those in their home country, and this was linked to job dissatisfaction. Cross-tabulation analysis of this small sample revealed that of the participants who were dissatisfied, all had larger caseloads than they had in their home country. In contrast, while Bruschini et al. (2018) did not comment on workload specifically, they did investigate demands using the HSE’s Management Standards Indicator Tool. No significant correlations were found between demand (which included workload) and burnout risk.

Data from qualitative enquiries supplemented the statistical information. Workload was the main source of stress for SLTs interviewed in Australia (McLaughlin, et al., 2008), and in the UK, Loan-Clarke et al. (2009) reported that over 20% of participants reported excessive workloads.

2.6.4.2 Control/Autonomy.

Due to the subjective nature of some of the reporting and the scarcity of correlational data, the evidence for job control and its relationship to stress in SLTs is inconclusive. Only one study specifically stated the investigation of control as an objective. Bruschini et al. (2018) found that a lack of control, as measured by the HSE Management Standards Indicator Tool (e.g., having the ability to make choices over how work is completed), was associated with a risk of burnout. Four other quantitative studies included some elements of control in their questionnaires, and both qualitative papers mentioned it.

Harris et al. (2009) reported that the Bureaucratic Restrictions subscale of the SLPSI – which contains some items that measure control - was strongly correlated ($r>0.79$) with stress scores i.e., dissatisfaction with bureaucratic restrictions was correlated with higher stress. Blood, et al. (2002a) found that clinicians working in healthcare reported being able to participate in making decisions about their jobs, were able to use their abilities to the fullest extent during their jobs and knew what type of job performance was expected. Clinicians therefore appeared to have adequate levels of control over occupational demands, resulting in low levels of stress around autonomy. Similarly, a lack of control over service delivery was not reported as a stressor for the school based SLTs in Blood et al.'s (2002c) study, in which stress was "barely noticeable".

Kaegi et al., (2002) found that the large majority of SLTs in their study had "enough authority to do their job" whereas, while interviewing clinicians, McLaughlin et al. (2008) identified stress in SLTs that was due to a lack of autonomy. Warden et al (2008) reported that SLTs struggled to gain the same level of control when working in comparison to when they were student practitioners. However, they did not comment on whether this affected their job satisfaction or stress.

2.6.4.3 Professional support.

Professional support (or the lack thereof) featured in seven studies. Three identified the contribution of a lack of support to stress or burnout, one linked support to job satisfaction, one reported that support was perceived to mediate stress, one described satisfaction with the support SLTs received, and the last mentioned sources of support for SLTs.

Harris et al. (2009) found that a lack of professional support accounted most strongly for an increase in stress and Bruschini et al. (2018) found that poor support from management was associated with an increased risk of burnout, but support from colleagues (e.g., strong team relationships) protected against burnout. Blood et al. (2002c) reported that little interaction with peers and supervisors as well as low functional support (i.e., support from family) predicted higher levels of stress. Smith-Randolph and Johnson (2005) reported that the presence of adequate support staff predicted job satisfaction. Kaegi et al. (2002) found that 64.5% of the 47 SLTs in Alberta and 33% of the nine in Ontario were satisfied with the help received from supervisors and were also satisfied with their jobs. When interviewed, clinicians in Australia identified support as mediating stress (McLaughlin et al., 2008) and SLTs in South Africa cited the multidisciplinary team and administrative colleagues as sources of support (Warden et al., 2008). The available data therefore implies that a lack of support contributes to dissatisfaction and stress/burnout in SLTs.

2.6.4.4 Work setting.

Four quantitative studies reported on the differences between groups: three compared rural to urban settings and one contrasted SLTs working in schools with those employed in medical settings. In addition, one qualitative paper mentioned work setting as a source of job satisfaction.

No difference in stress between rural and urban settings was found by the three studies that compared these groups of clinicians (Blood, et al., 2002c; Blood, et al., 2002b; Harris, et al., 2009). Kalkhoff and Collins (2012) compared clinicians working in schools across the USA to those working in medical settings and reported that those employed in medical settings were significantly more satisfied generally than those employed in schools. Specifically, SLTs in medical settings were significantly more satisfied with promotion, contingent awards, operating conditions, and co-workers. Finally, clinicians interviewed by Warden et al. (2008) reported that they found working in a teaching hospital environment to be a source of job satisfaction.

2.6.4.5 Length of time in practice.

Length of time working was reported in five papers. Kaegi et al (2002) identified a negative association between job satisfaction and the length of time working for school based SLTs. Contrastingly, Blood, et al. (2002b) reported that increasing number of years in a job was a predictor of increasing job satisfaction for school based SLTs in their study. Blood, et al. (2002a) also reported significant correlations between lower stress and years at the current job, with those who had been working longer reporting lower levels of stress. Bruschini et al. (2018) found no significant correlation between the length of time worked and the risk of burnout, and Kalkhoff and Collins (2012) reported no significant relationship between the length of time an SLT had been in their current job and their job satisfaction.

2.6.4.6 Salary.

Seven studies included salary as a factor that contributed to job satisfaction or stress. Blood et al. (2002c) found that an "inadequate salary" featured in the top eleven sources of stress for school based SLTs, with 33% of participants reporting it as a perceived stressor. Forty percent of the 382 participants in Edgar and Rosa-Lugo's (2007) study were dissatisfied with their salaries and Blood et al. (2002b) reported that SLTs in their sample had low satisfaction with pay. SLTs working in healthcare also reported feeling that they were inadequately paid (Blood 2002a), and half of the 23 clinicians surveyed by Cocks & Cruice (2010) were dissatisfied with their salary. Unhappiness with salary was also associated with an increase in stress in the study by Harris et al. (2009). Smith-Randolph and Johnson (2005) stated in their abstract, discussion and conclusion sections that "intrinsic factors such as competitive pay" were weaker in significance for predicting career satisfaction and desire to stay in the job. However, there was nothing in the results section that specifically mentioned this. Overall, findings do suggest a link between perceived incommensurate salary and job dissatisfaction and stress/burnout.

2.6.5 The effect of SLT job satisfaction, stress/stressors and burnout on recruitment and retention.

The main effect of job satisfaction, stress/stressors and burnout which has been investigated over the last twenty years, is worker movement. The effects of job satisfaction and/or stress/stressors on recruitment and retention were reported in five studies. Analysing responses to open-ended items on a questionnaire, Loan-Clarke et al. (2009)

reported that 13% (n=310) of participants cited job satisfaction/enjoyable or interesting work as a reason to remain working in the National Health Service (NHS) in the UK. Conversely, 7.5% (n=110) stated that job satisfaction in their new place of work meant that leaving the NHS had been the right thing to do. The authors also reported that 6.8% (n=162) of their participants described specific stressful events as a reason to "seriously think about leaving" the NHS, 20.2% (n=109) left the NHS due to stress, and 13.3% felt that stress reduction was an action that could be taken by NHS management to increase the chance that they would remain in or return to the NHS.

Heritage et al. (2018) reported that a lack of job satisfaction contributed significantly to the intention to leave the profession. In addition, their qualitative content analysis identified elements of job satisfaction which encouraged participants to stay in their current position (e.g., the fulfilling nature of the job) and revealed that workload-related stress was related to SLTs' decision to attempt to find a different position.

Dissatisfaction with workload was identified to have the biggest impact on retention (i.e. remaining in a current position) by Edgar and Rosa-Lugo (2007), and dissatisfaction with salary interacted with both retention and longevity. Finally, clinicians interviewed by McLaughlin et al. (2008) made connections between job satisfaction, stress, barriers to clinical effectiveness and leaving their current position.

Finally, McLaughlin et al. (2010) investigated SLT intention to leave their job and the profession. While the authors did not comment on stress levels per se, they did identify particular stressors which predicted intention to leave. Low job security predicted intent to leave a job and spending more than 50% of one's time on administrative duties predicted intent to leave the profession. Scoring low on the 'positives of the profession' e.g. not having professional needs met, predicted both intent to leave the job and intent to leave the profession. A low score on the ASSET psychological well-being score did not predict intent to leave the job or leave the profession. Participants who achieved a higher negative affect score as measured by the Positive and Negative Affect Scale (PANAS) were more likely to leave the profession.

2.7 Discussion

The objective of this review was to investigate the current status of SLTs, with respect to well-being, job satisfaction, stress and burnout, and to explore factors associated with, and the effect of, these outcomes. Evidence in the data for the presence and levels of job satisfaction and stress/burnout, the contributory elements of a job to these constructs, and their impact, was integrated.

Comparison of findings is problematic, due to differing methodologies and a variety of study foci. Context varied widely and inclusion of statistical reporting was mixed, with some studies concentrating on descriptive measures and others using inferential tests. However, it was possible to identify certain themes, facilitating a review that used the principles of a systematic review, but is thematic in nature (Dixon-Woods, et al., 2005).

The review revealed high levels of job satisfaction for SLTs in the USA and Canada. The data regarding stress and burnout is less conclusive. Studies did not provide compelling evidence for the presence of high levels of negative stress, and there were conflicting reports about the presence of burnout. However, papers reporting on retention and recruitment identified stress as one of the reasons that SLTs leave their jobs.

In the studies reviewed, there did not appear to be strong links between methodology and interpretation of findings; and established theories of occupational health at work. For example, three themes related to the Job Demand Control Support model (Johnson & Hall, 1988; Karasek, 1979), yet no individual study adopted or even mentioned this framework. As described in Chapter One, the JDCS model has been used extensively in research investigating the biopsychosocial work experience – it could potentially be applied to the SLT workforce in the future. In the studies identified in this review, the main way of operationalising demand was to consider workload or caseload size. The review found consistent evidence that excessive workloads and/or caseloads are correlated with a lack of satisfaction and an increase in stress and burnout. Evidence was also found for a relationship between a lack of control and higher stress/burnout, but no study focused on the relationship between control and job satisfaction. A lack of professional support appeared to be correlated with both stress/burnout and job dissatisfaction.

The evidence for the remaining three themes was variable. The link between perceived inadequate salary and dissatisfaction and/or stress appears to have been confirmed, but there was mixed evidence regarding the impact of the length of time worked, and limited evidence with regards to the role of work setting, with only one study finding that SLTs working in medical settings in the USA were more satisfied than those working in schools. Future work is necessary to determine the impact of these variables on SLTs' job satisfaction, stress and burnout.

Several studies investigated recruitment and retention in the profession. While attention on recruitment/retention is necessary for influencing policy and practice, there has been scant attention paid to the mental health of SLTs as a workforce. This review identified that job satisfaction, stress and burnout are important considerations for healthcare organisations aiming to improve recruitment and retention of staff.

2.7.1 Methodological issues.

Several methodological shortcomings were identified in this research area. Firstly, study design was restricted to cross-sectional surveys and there are no longitudinal studies on investigating well-being. The paucity of qualitative studies means that there is meagre rich, in-depth data that might offer an insight into the lived experiences of SLTs. A further methodological restriction involved the measurement of job satisfaction. Almost half the papers reported using self-designed questionnaires and in no instances was construct validity discussed. Moreover, the determination of sample size received scant attention. Studies did not always include information that allowed for meaningful comparison between, for example, the sample and pre-established norms. In addition, only two studies provided effect sizes.

2.8 Strengths and Limitations of the Review

This is the first review that has aimed to synthesise research about the occupational well-being of speech-language pathologists. A strength of the review is its broad approach, which enabled the synopsis of information sourced from a disparate body of literature. The dissimilar nature of the studies resulted in the inability to determine the strength of evidence for the themes identified, which might be viewed as a limitation of the review. However, the presentation of the data provides insight into some aspects of the well-being

of SLTs, as well as the causes for and effects of job satisfaction and stress/burnout in this workforce.

As in every review, bias may have occurred. First, this review is limited by its exclusion of non-English language papers. However, a lack of resources meant that the translation of texts from other languages into English language was not possible. A second concern is possible publication bias, as studies which report statistically significant results may be more likely to be published in scientific journals (Song, Hooper & Loke, 2013). However, due to limited resources, only studies identified in electronic online searches were included in the review.

2.9 Addendum

Since this systematic review, one article (Oh, 2019) reporting SLT stress was published, this did not form part of the above review. While Oh did not detail recruitment methods, they reported a 92.9% response rate for their questionnaire, following distribution to SLTs working in two major cities and one province in South Korea. They reported that the Korean Occupational Stress Scale – Short Form (KOSS-SF) was reliable (α=0.85) and that the overall stress level of their participants was M=56.68, SD 7.95, (maximum value=100). They did not, however, comment on whether this score was viewed as of concern or not. Job demands, perceived inadequate compensation and ‘relationship conflicts’ (that described support by colleagues and managers) were the highest stressors reported, adding information to the themes identified in the review.

2.10 Conclusion and Further Rationale for Research Questions

In summary, the identified themes in the literature investigating workload/caseload size, control, professional support, salary, length of time in practice and work setting have been reviewed. However, the impact of many of these risk factors on SLT satisfaction and general biopsychosocial well-being remains poorly understood. There is a need for more theoretically driven studies on the topic, and a need for longitudinal data to establish cause and effect relationships between predictor and outcome variables. Furthermore, there are no previous studies that have investigated the interaction between different psychosocial elements of the job, which might boost satisfaction or ameliorate stress in SLTs. In addition, limited information on the contribution of individual differences to SLT well-being

is available. No studies investigating self-employed SLTs were sourced. Finally, information on how practising SLTs interpret their occupational experiences, or what meaning their experiences hold for them, is scarce.

Considering further research through a UK specific lens, additional issues are apparent:

While there are numerous studies that investigate job satisfaction or stress among SLTs, the majority of these have taken place outside of the UK, with some commenting on their results being difficult to generalize (e.g., Blood, et al., 2002(b); Harris et al., 2009; Kaegi et al., 2002; Smith-Randolph & Johnson, 2005). Since 1998, only two studies have been published in the UK (Cocks & Cruice, 2010; Loan-Clarke, et al., 2009).

In addition, the UK studies are dated. The latest paper published was in 2010, when Cocks and Cruice surveyed 23 overseas trained SLTs who were practising in the UK and stated that results were difficult to generalise. Data collection for the most recent national study (Loan-Clarke et. al., 2009) took place in 2005. The UK economy entered recession in late 2008. In response to this the government at that time undertook an austerity programme, aimed at reducing the budget deficit. The resulting recession-induced changes to the workplace have significantly lowered employee well-being (van Wanrooy et al., 2013) but whether this is the case for SLTs remains to be seen.

Furthermore, the focus of Loan-Clarke et al.'s study in 2009 was on recruitment and retention of NHS AHPs. As mentioned before, while attention on recruitment and retention within the NHS is necessary for influencing policy and practice, there has been little attention paid to the mental health of SLTs as a workforce. The mental well-being of workers is a key resource for productivity (European Commission, 2008) with some arguing that well-being should be the primary focus when measuring a nation's progress and for guiding policy (Layard, 2009). Furthermore, presenteeism is high in the NHS (Harvey et al., 2009). Scrutiny of the factors that either promote or undermine the well-being of the SLT workforce in the UK therefore bears consideration.

Absent from the UK literature is any examination of the occupational well-being of SLTs working outside of the NHS generally, or as independent practitioners specifically. Loan-Clarke et al. (2009) suggested that while there was limited opportunity for employment for SLTs outside the NHS at the time of their study, the situation might change due to

alterations in commissioning and service provision, which could result in more therapists becoming self-employed. As previously described, the landscape of SLT has indeed changed, with 27% of the workforce now working outside the NHS. This means that there is no up-to-date information about the well-being of the current workforce.

2.11 Research Questions and Objectives

The above conclusions led to further development of the research questions to include specific objectives, as follows:

Research question 1: What is the occupational well-being of SLTs currently working clinically in the UK?

The objectives relating to question 1 were to:

i. Describe the current psychosocial work environment (operationalised as demand, control and support) of SLTs practising clinically in the UK.
ii. Apply the JDCS model (Karasek, 1979, Johnson & Hall, 1988) to the data, to classify jobs held by participants.
iii. Investigate the meaning that SLTs give to their work experiences and well-being.
iv. Explore the occupational well-being of SLTs, operationalised as job satisfaction.
v. Examine the additive effects of job demands, control and support on job satisfaction.
vi. Establish the interaction effects of job demands, control and support on job satisfaction.
vii. Consider the mediating effect of individual differences on the relationship between the psychosocial work environment and occupational well-being.
viii. Compare the occupational well-being of those who are employed to those who are self-employed and to those who straddle both employment settings.

Research question 2: What is the general biopsychosocial well-being of SLTs in the UK?

The objectives relating to question 2 were to:

ix. Describe the general biopsychosocial well-being of SLTs, operationalised as incidence of somatic symptoms, levels of anxiety, depression, and social dysfunction.
x. Compare the general biopsychosocial well-being of those who are employed to those who are self-employed and to those who straddle both employment settings.
xi. Examine the influence of the biopsychosocial work environment on general biopsychosocial well-being.
xii. Examine the additive effects of job demands, control and support on general biopsychosocial well-being.
xiii. Establish the interaction effects of job demands, control and support on general biopsychosocial well-being.
xiv. Explore the factors perceived by SLTs to influence their general biopsychosocial well-being.

To meet the above objectives and thus answer the research questions, the study contained two phases, within a mixed-methods approach. This approach advocates for integration that begins at the design stage of a project and is not limited to the analysis stage only (Bazeley, 2018). Adhering to this stance, each phase of the study was designed to elicit data that would contribute to both research questions:

The first phase consisted of a large-scale, longitudinal survey. This yielded both quantitative and qualitative data and provided information of a nomothetic nature, enabling conclusions to be drawn about the workforce, facilitating generalisation to the larger population, and allowing the possibility for recommendations to be made at service and/or policy levels.

The second phase comprised a round of semi-structured interviews to explore the perceptions of SLT's work experiences, and to listen to their views about their well-being, thus acknowledging and valuing the individual voices of SLTs in the UK. Table 2.3 presents the contribution of each study to the objectives.

Table 2.3. The contribution of the two studies to meeting the objectives

Objective	Phase 1	Phase 2
i	X	X
ii	X	
iii		X
iv	X	X
v	X	
vi	X	
vii	X	X
viii	X	X
ix	X	X
x	X	X
xi	X	X
xii	X	
xiii	X	
xiv		X

The next chapter will outline the methodology and methods used to answer the research questions.

CHAPTER THREE: METHODS

3.1 Overview of the chapter

This chapter details the mixed methods approach taken to answer the research questions and meet the set objectives. The philosophical assumptions that underpin the study are described, followed by the theoretical foundations and research design. The rationale for the selection of a sequential explanatory mixed methods design is explained and ethical considerations are presented. The remainder of the chapter describes the two phases of the current study, providing details about the population, sampling, materials, procedure and data analysis for each phase.

3.2 Philosophical Assumptions: Pragmatism

The philosophy underpinning the current mixed methods study was pragmatism. While there are other philosophies (e.g., constructivism, critical realism or transformative philosophy) that can be linked to mixed method approaches (Creswell & Plano Clarke, 2018), pragmatism is viewed as an important philosophy for mixed methods research (Teddlie & Tashakkori, 2009) and arguably "represents a model of 'normal science' among…mixed methods researchers" (Biddle & Schafft, 2015, p320).

The current study is framed within classical pragmatism, taking the view that being and knowledge are continually changing and shifting, and adopting a middle ground between the materialist position i.e., that the world is composed of matter; and an idealist stance i.e., *ideas*, including those of social and cultural origin, are 'real' (Bertman, 2007). Pragmatism therefore embraces both the external world independent of the mind and the subjective perception of the world. It rejects the either/or stance that requires a choice between positivism and constructivism. It proposes instead a compatibility thesis, agreeing with the post-positivist position that advocates for the existence of an external reality but denying that the 'truth' regarding that reality can be ultimately determined i.e., that one explanation is necessarily better than another (Smith, Flowers & Larkin, 2009). In this way, it allows for ontological pluralism, which facilitates the use of mixed methods. Because multiple methods of data collection are endorsed within classical pragmatism, both quantitative and qualitative sources of data are employed to answer research questions (Creswell, 2007). The acknowledgement that human experience is multidimensional and

multi-ontological, means exploration is better served by combining methods, and embracing the differences that different paradigms can bring aids understanding of the complexities of human experience (Shaw & Frost, 2015).

Pragmatism also prioritises the consequences or practical implications of research (Creswell, 2013) and this current study endeavoured to keep these in focus by having an ultimate goal of improving the working conditions and maintenance of occupational biopsychosocial well-being for SLTs. It was hoped that a clinical consequence of the research would be that the findings could be used to support SLTs employed in the NHS and other sectors by enabling them to initiate more open dialogue between them and their employers, thus improving retention of the workforce through the adaptation of workplaces to people. Furthermore, the RCSLT works with national agencies in the four home nations – NHS England, Public Health England, Public Health Scotland, Public Health Wales, and the Public Health Agency in Northern Ireland; to raise awareness of issues within the profession, including the health of the workforce. The lobbying position of the RCSLT may be strengthened through the availability of evidence about well-being from the workforce themselves (C. Moser, personal communication, 08.05.18).

3.3 Theoretical Foundations for the Study: Mixed Methods Rationale

Mixed methods link and combine quantitative and qualitative strands of a project, enabling researchers to answer complex questions, to generate and/or test theory and to corroborate findings (Tashakkori, Teddlie & Sines, 2012). Within mixed methods, an 'emtic' orientation may be used to achieve these aims. Onwuegbuzie (2012) coined the term 'emtic orientation' to refer to the interaction between an etic perspective (where a group is studied by an outsider, and typically seen in quantitative research) and an emic approach (where a group is studied by an insider, and frequently seen in qualitative research). This combined orientation is a hallmark of mixed methods research (Onwuegbuzie & Collins, 2017), and was employed for the current study. To the researcher's knowledge, the current study was the first of its kind to do so in order to investigate SLT well-being, facilitating a unique contribution to the field.

In addition, it is possible to establish whether participant views from standardised instruments and interviews converge or diverge. In short, mixed methods allow researchers to "situate numbers in contexts and words of participants, and they frame the

words of participants with numbers, trends, and statistical results" (Creswell & Plano Clark, 2018, p23). The RCSLT has recognized the value of mixed methods research. The Head of RCSLT Policy at the time of the study stated at the RCSLT conference (September 2017) that while policy makers use numbers to help them to prioritize competing demands, it is often the evidence provided by the voices of those who stand to benefit from change, that determine decisions. With the hope that results from this current study might ultimately impact on the SLT workforce to improve their well-being and facilitate enhanced job design for them, the RCSLT could be a potential strategic partner in the future. Viewing the two methods as complementary, along a continuum, allowed the researcher to combine them in a manner that acknowledged the strengths and weaknesses of each and to ultimately consider together the results of each phase of the research.

3.3.1 Research design: A sequential explanatory mixed methods approach.

This section will describe the defining characteristics of the sequential explanatory mixed methods design that was used for this study, including the overall purpose of the design as well as the timing and emphasis of each element. It will also provide the rationale for the choice of this design, along with relevant examples of its use from the literature. The types of mixed methods designs have been broadly categorised by Creswell and Plano Clarke (2018) into three core designs: exploratory sequential, explanatory sequential, and convergent designs.

The current study utilized an explanatory sequential design, which consisted of two phases. Quantitative results were further elucidated and built upon through the use of qualitative data. With the research questions in mind (investigation of occupational and general biopsychosocial well-being, including the comparison of SLTs in different settings, and incorporating the subjective perceptions of participants) it was felt that this design was apposite. The procedure for the approach taken in this study is shown in Figure 3.1.

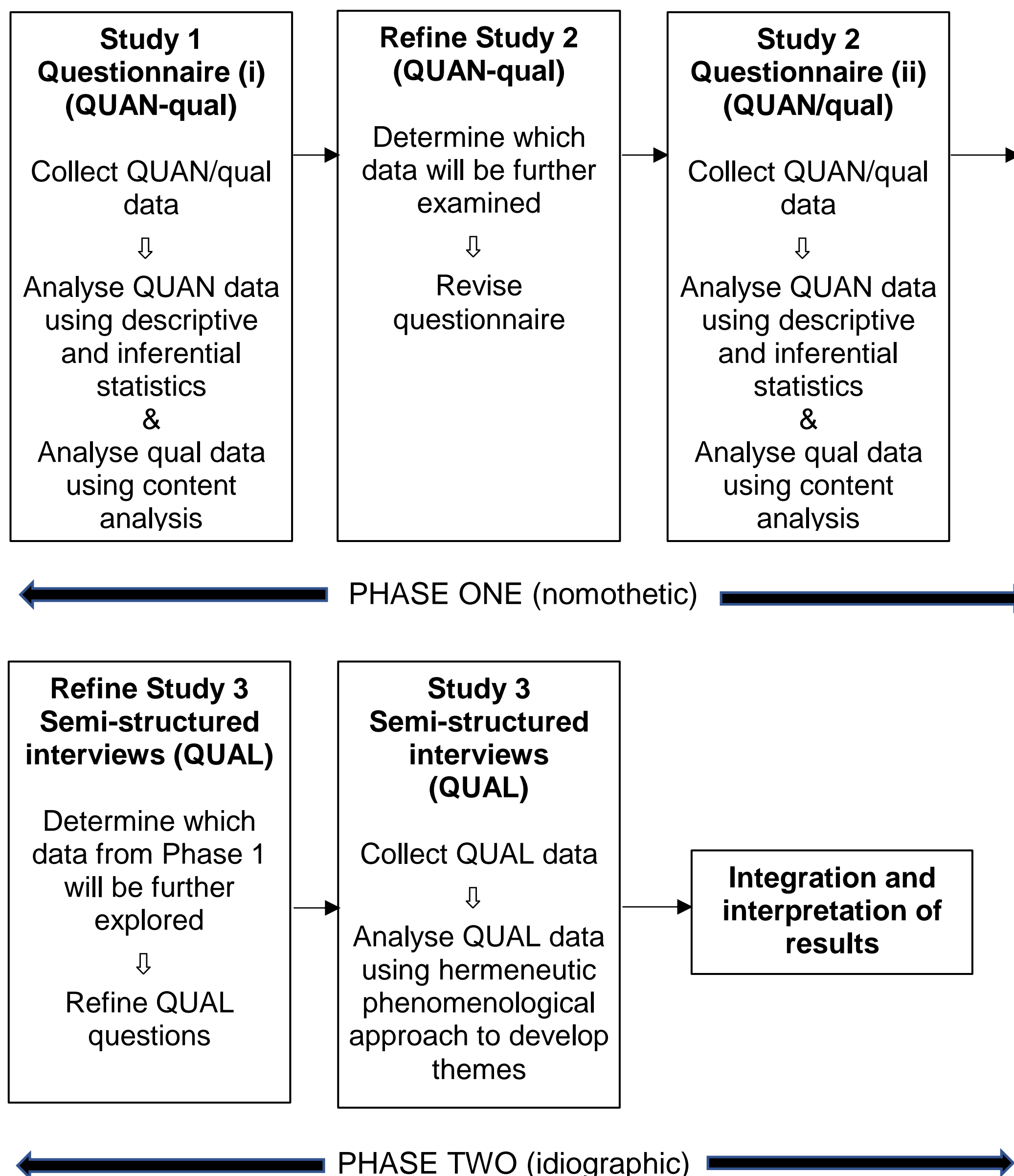

Figure 3.1. Procedure for sequential explanatory mixed methods approach. Adapted from Creswell & Plano Clark (2018)

Note: QUAN indicates quantitative component; QUAL indicates qualitative component. Capitals indicate where component is typically emphasized or prioritized in this design. (Lower case would indicate component is typically used in a supportive capacity).

The majority of the extant literature investigating the well-being of SLTs has used quantitative methodologies, providing the rationale for beginning with the quantitative phase of this current study, as comparison with existing studies was made possible. In addition, the over-arching themes of demand, control, and support were identified within the literature, lending themselves to the use of the JDCS model (Johnson & Hall, 1988; Karasek, 1979). This provided a theoretical basis on which to frame questions that could

be utilized with large groups. Furthermore, the extant literature provided information on which to base the design of the questionnaire, as well as examples of published scales previously used to gather information, meaning it was not necessary to first explore the area using qualitative techniques in order to then generate topics for a questionnaire.

Creswell and Plano-Clarke (2018) stress the importance of the integration of results and the need to be explicit about when mixing occurs in a study. For this work, 'mixing' is held to mean the joint consideration of different elements of the research, where each maintains its individual integrity, and not the blending of concepts to form one idea. This thinking underpinned each stage of the current study, from the initial generation of research questions, to the design of the study, through the methods employed to answer the questions and finally to the analysis and reporting of results.

3.4 General Ethical Considerations

The current study was approved by Birmingham City University's Faculty of Business, Law and Social Sciences *Faculty Research Ethics Committee* (BCU 's BLSS FREC) (Appendix C1) and adhered to the Code of Ethics and Conduct (British Psychological Society, 2009) and the Code of Human Research Ethics (British Psychological Society, 2014).

3.4.1 Phase one ethics.

Two online questionnaires (three months apart) were used in the current study; each received ethical approval from BCU's BLSS FREC (Appendix C2 & C3). An online survey tool, utilizing Qualtrics® survey software (2018), included information sections and consent forms for both questionnaires. Continuation of the questionnaires was only possible once the participant had confirmed that they had both read and understood the information provided, and that they consented to participate. The information and consent forms included in both online questionnaires are presented in Appendix C6. Between the two publication dates of the survey (April 2018 and September 2018), the General Data Protection Regulations (GDPR, Data Protection Act, 2018) came into force. Qualtrics ® (2018) is fully compliant with GDPR requirements.

3.4.2 Phase two ethics.

BCU's BLSS FREC separately approved this element of the study (Appendix C4 & C5). Participants were provided with an information form and data protection form, compliant with GDPR requirements (Appendix C7i & C7ii). The self-determination of participants was considered by including the right to withdraw, or have data removed prior to analysis. An example of participant self-determination is provided in Appendix C8. Interviewees signed a consent form prior to commencement of the interview (Appendix C7iii). In addition, once the interview had been completed, the researcher verbally checked with participants that they were happy for the content of the interview to be used. Finally, a summary of the interview was sent to each participant, and they were provided with the opportunity to state whether information was correct, and whether there was information that they did not wish to be included in the data analysis. They were given four weeks in which to reply, as the researcher planned to begin analysis following transcription, which it was estimated would take a month to complete.

3.5 Phase One: A Large-Scale Longitudinal Survey

3.5.1 Overview.

In the first phase, a non-experimental observational study utilizing a longitudinal design was used, as the study aimed to establish the characteristics of the speech and language therapy workforce, and the prevalence of particular phenomena (Bishop, 2015; Kumar, 2011). A large-scale survey strategy was employed, and the method of investigation was two anonymous online questionnaires. The two questionnaires (with a three-month interval between them) each yielded mostly quantitative data, and a small amount of qualitative data.

3.5.2 Survey at time point one (T1)

The first element of phase one gathered nomothetic data about the population under investigation. Data was gathered between April 2018 and July 2018.

3.5.2.1 Population.

The theoretical population being studied consisted of all SLTs that were practising clinically in the UK, at the time that the current study took place. *Practising clinically* was operationalized as holding an active caseload. As all practising clinicians are required to be members of the HCPC, membership statistics provide the most accurate information regarding the number of SLTs currently working in the UK. At the time of the current study, their latest published figures (April 2017) listed 15,932 SLTs who were HCPC members. The HCPC number included all SLTs, not only those who work clinically (e.g., it also included those working in higher education, research, consultative positions within the professional body, etc.). It was therefore not possible to determine the precise size of the population that held active caseloads. Moreover, the HCPC did not keep information regarding where or how SLTs are employed, nor did the information include whether clinicians worked full- or part-time.

3.5.2.2 Sample size.

To determine the sample size needed to be able to detect any relationship between the variables being investigated, a power analysis was performed (Dancey & Reidy, 2017). A calculation using G*Power 3.1.9.2 (Faul, Erdfelder, Lang, & Buchner, 2007) was conducted, with the type of test being specified as multiple regression. The current study aimed to use the General Health Questionnaire (GHQ). Therefore, previous studies utilizing the GHQ to investigate the effect of the psychosocial workplace on well-being were used to determine a likely effect size. The calculation employed a significance level of $p=0.05$, minimum power of 0.80 and a small possible effect size ($r^2=0.03$); and indicated that a sample size of 607 was required. This relatively large size was reflective of the current study aiming to investigate the effect of eight predictor variables (JDCS job types), as well as the role of five mediating variables (individual differences) on the outcome variables (job satisfaction and general biopsychosocial well-being).

3.5.2.3 Sampling strategy.

Pre-empting data protection concerns, the researcher did not expect to be provided with a list of HCPC members and their contact details. Instead, the HCPC was contacted to ascertain whether they would be in a position to assist with the procurement of participants

by forwarding a link to the online questionnaire (via email) to registrants, on behalf of the researcher. They were unable to help, stating that their reason for this was because they are a small organization without the resources to assist. The next step was to contact the RCSLT as many UK SLTs are registered with the RCSLT, in addition to being members of the HCPC. In March 2018, there were 14,267 practicing members registered with the RCSLT (RCSLT Bulletin, September 2018). The only previous large-scale study in the UK of the SLT workforce (Loan-Clarke, et al., 2009) utilised the RCSLT membership list as a sampling frame, and the organisation was therefore approached to determine whether they would be able to support the distribution of the online questionnaire. While the RCSLT was supportive of the study and agreed to help with the dissemination of results (Appendix C9), they stated that they were unable to assist with recruitment of participants, as they received numerous requests for help with surveys and therefore did not promote, nor assist with the identification or recruitment of participants for surveys.

Failure to procure a membership list of the profession prohibited random sampling and meant that selective sampling (Beidernikl & Kerschbaumer, 2007) and snowballing (Fink, 2003) was initially used. This form of non-probability sampling is potentially susceptible to bias which may threaten the generalisability of findings. However, it is appropriate when the aim of an exercise is to gather information to describe a specific group, but a population listing (or in this case membership list) is not available (Fink, 2003, Henry, 1990).

3.5.2.4 Recruitment Process.

To encourage candid responses about experiences at work, potential participants were contacted independent of their employing organisations (De Vos & Meganck, 2009). In January 2018, an article by the researcher was published in the RCSLT Bulletin, the official monthly magazine published by the professional body, which is sent to all members of the RCSLT (Appendix C10). This served as pre-notification of the study, a recognised strategy to increase response rate (Edwards, et al., 2009). Pre-notification aimed to alert SLTs that the survey would shortly be available and also to generate interest in the study. After publication of the article in Bulletin, 68 SLTs emailed the researcher directly, expressing an interest in participating in the study.

In April 2018, the 68 SLTs who had expressed interest in the study following the article that appeared in the RCSLT Bulletin were each emailed a personalised message, another strategy that has been found to increase response (Edwards, et al., 2009). The respondent was addressed by name and the email neutrally reflected or reiterated statements that the participant had made when they originally contacted the researcher. The message contained a link to the online questionnaire and asked the participant to please forward the link to colleagues. An example of such an exchange is presented in Appendix C11.

At the same time, RCSLT Clinical Excellence Networks (CENs) were sent an email containing the link and asking chairs to forward the link to their membership. The CENs are regional or national support networks of SLTs specialising in particular clinical areas, and contact details of the chairs are published on the RCSLT website. Of the 116 CENs, 56 had NHS email addresses listed as their contact details, and as NHS ethical approval was not sought for this study (following the decision to contact participants outside of their work environments), these addresses were not usable. Therefore, the remaining 60 CENs were contacted.

In addition to the above measures, further 'passive' recruitment (Beidernikl & Kerschbaumer, 2007) was used. This was achieved through the publication of the link to the questionnaire via the following web-based channels:

1. The May 2018 edition of the RCSLT e-Research newsletter
2. The online ASLTIP* forum (available to all ASLTIP members)
3. The IPSLT** Yahoo Group

*ASLTIP – the Association of Speech and Language Therapists in Independent Practice – is an organisation to which many independent SLTs voluntarily belong
**IPSLT – the Independent Practitioners in Speech and Language Therapy – is an online support group for any SLTs in independent practice

Finally, social media was used. On Twitter, a direct message was sent to UK-based SLTs who followed the researcher. A general public tweet was not sent, as this ran the risk of the questionnaire being available to non-SLTs. Seven weeks after the survey was initially made available, funding from BCU was procured and an advertisement for the study, written by the researcher, appeared in the RCSLT Bulletin on 4 June 2018 (Appendix C12).

The details of the study were also retweeted at this point. There was an initial spike in responses following advertising, and the survey remained open for a further seven weeks. In total, the initial survey was available to SLTs from 16 April 2018 to 18 July 2018.

3.5.2.5 Materials.

A questionnaire (Appendix C6), for self-completion by participants, was designed by the researcher for interactive online use. It included mostly closed-ended questions and consisted of four sections, which aimed to gather information about participant demographics, working profiles, job characteristics and biopsychosocial work environments, dispositional traits, and well-being.

Demographics, working profiles, job characteristics and biopsychosocial work environments.

The first section began with five questions regarding demographic information, including: age, gender, relationship status, ethnicity and how many children were looked after at home by participants at the time of the survey.

The section continued with questions about working profiles, job characteristics and the biopsychosocial work environment. These were informed by the literature review and the researcher's own experience as an SLT working in the UK. Questions were aimed at establishing the nature of employment and the features of the jobs that SLTs currently do (e.g., whether they were employed/self-employed/worked in both sectors, how many hours a week they were paid to work, where they worked, the number of settings they worked in (e.g., school & community clinic), the number of sites they visited weekly, the size of their caseload). Questions were carefully worded to ensure that they were understood by participants and possessed good face validity.

The psychosocial work environment was further explored through the use of the Speech-Language Pathologist Stress Inventory (SLPSI) (Fimian, Lieberman, & Fastenau, 1991), which includes questions that address elements of work that are specific to SLTs. The four SLPSI subscales that evaluate 'sources of stress' ('Time & Workload Management', 'Bureaucratic Restrictions', 'Instructional Limitations' and 'Lack of Support'), were used to evaluate the psychosocial work environment.

A full description of the SLPSI is provided in the *Well-being Outcomes* section, as the inventory includes subscales that investigate stress outcomes.

Dispositional traits.

The next section aimed to establish individual differences in participants, to investigate whether these differences had a mediating effect on outcomes. Self-esteem, self-efficacy, positive affect, negative affect, locus of control and optimism were included, and assessed using single-item questions. Likert scales ranged from 1-10, with 1 being low on a particular trait, and 10 being high. Inclusion of items was based upon the following rationales:

- Self-esteem, generalized self-efficacy, affect, locus of control (Judge et al., 1998), and optimism (Diener, Oishi, & Lucas, 2003) are characteristics that are associated with well-being, and that influence well-being (Judge, et al., 1998; Tavousi, 2015).

In addition, single-item questions were included to investigate anxiety, depression, and life satisfaction, for the following reasons.

- Anxiety and depression are recognised outcomes of 'high strain' jobs (Häusser, et al., 2010).
- Life satisfaction: the relationship between job characteristics, job satisfaction and life satisfaction is relatively strong (Judge, et al., 1998).

Well-being outcomes.

The final section of the questionnaire aimed to establish what the outcomes of various elements of a job, on the well-being of SLTs, might be. It contained the following published scales:

The Speech-Language Pathologist Stress Inventory (Fimian et al, 1991)
The Generic Job Satisfaction Scale (Macdonald & MacIntyre, 1997)
The General Health Questionnaire – 28 (Goldberg, 1972)

The Speech Language Pathologist Stress Inventory (SLPSI).

The SLPSI (Fimian, et al., 1991) is a 48-item questionnaire designed to measure stress specific to SLTs working in schools in the USA and has previously only been used in the USA (e.g., Blood et al., 2002c, Harris, et al., 2009). It has six subscales, four that measure sources of stress and two that measure manifestations of stress:

Sources of stress:

a. Time and workload management e.g., *My caseload is too big*.
b. Bureaucratic restrictions e.g., *Administrative policies limit my effectiveness*
c. Instructional limitations e.g., *I experience inflexible scheduling*
d. Lack of professional supports e.g., *I lack recognition from other professionals*

Manifestations of stress:

e. Bio-behavioural manifestations e.g., *I experience heart racing or pounding*
f. Emotional-fatigue manifestations e.g., *I feel fatigued*

Individual items on the scale are measured using a five-point Likert scale, with 1 indicating little agreement with a statement and 5 meaning most agreement. Responses to questions include: *not noticeable/no strength (1), barely noticeable/mild strength (2), moderately noticeable/medium strength (3), very noticeable/great strength (4), and extremely noticeable/major strength (5).* A 'Total Stress Score' is reached by calculating the mean of all 48 items. In addition, it is possible to calculate subscale scores, by averaging items within a subscale. Some minor linguistic changes were made to the SLPSI. These changes did not alter the constructs being investigated and are detailed in Appendix C13.

The Generic Job Satisfaction Scale (GJSS).

The GJSS (Macdonald & MacIntyre, 1997) is a 10-item scale that was developed to provide a short, generic metric that could be used across a wide range of occupations. Examples of items include *I get along with my supervisors*, and *I feel good about my job.* It uses a five-point Likert scale, with responses scoring from 1 to 5. Responses include: *strongly disagree (1), disagree (2), don't know (3), agree (4), and strongly agree (5)*. Scores are added, and the level of job satisfaction is then determined (10-26=very low, 27-31=low, 32-38=average, 39-41=high, 42-50=very high). The GJSS appears to have been developed for use with participants who are organizationally employed as two items are

not applicable to those participants who are self-employed. These are: *I believe management is concerned about me* and *I get along with my supervisors*. A *not applicable* option was therefore added to the scale.

The General Health Questionnaire-28 (GHQ-28).

The GHQ-28 (Goldberg, 1978) is a screening device for identifying minor psychological disorders in the general population; it is widely used in occupational health research (e.g., Khamisa et al., 2017; Walker et al., 2015). The GHQ-28 consists of four subscales, each containing seven questions. The subscales are:

a. Somatic symptoms e.g. *Have you recently been getting any pains in your head?*
b. Anxiety/insomnia e.g. *Have you recently felt constantly under strain?*
c. Social dysfunction e.g. *Have you recently felt on the whole you were doing things well?*
d. Severe depression e.g. *Have you recently felt that life isn't worth living?*

The GHQ-28 uses a 4-point Likert scale, responses are typically: *not at all* (0), *no more than usual (1)*, *rather more than usual (2)*, and *much more than usual (3)*. Scores range from 0-3 for each item, with possible totals for the metric ranging between 0 and 84. While the GHQ is not intended to have predictive validity (Goldberg & Williams, 1988), *psychiatric caseness* is a 'probabilistic term' (Jackson, 2007) – a respondent who exceeded the threshold would be more likely to receive 'further attention' if they visited a General Practitioner. Using the Likert Score, the threshold for *psychiatric caseness* is 23/24. Goldberg (1972) recommends using a binary scoring method by transforming the two 'lesser' scores (0 & 1) to 0 and the two 'greater' scores (2 & 3) to 1. Using this method, any score that exceeds the threshold value of 3 is classed as achieving *psychiatric caseness*. Binary scores on the GHQ-28 can be further classified into three bands (Nolan & Ryan, 2008): no distress (scores ≤ 3); mild distress, likely to resolve without intervention (scores 4-6); and severe distress – unlikely to resolve without intervention (scores ≥ 7). This assists in identifying those participants at greater risk of requiring intervention.

The questionnaire concluded with an open-ended item that asked, "*Finally, is there anything else you would like to say?*" This question allowed participants to clarify, add further information, or share their feelings in more detail.

3.5.2.6 Piloting the questionnaire.

In January 2018, the online questionnaire was piloted for the following reasons: to establish the time it would take to complete; to identify potential problems such as comprehensibility and workability (Ma & McCord, 2007) and to test the adequacy of the questionnaire (Teddlie & Tashakkori, 2009). Five clinicians, who were all white British females, were identified to take part in the pilot, their demographic details are presented in Appendix C14.

Participants were required to provide feedback by completing a form about the questionnaire (Appendix C15). Three main issues with the questionnaire were revealed. These issues, and how they were addressed, are detailed in Table 3.1, and the final questionnaire is presented in Appendix C6.

Table 3.1. Issues identified through the pilot study, and responses to these

Issue identified	**Response**
Job task question confusing, therefore took too long	The question was rephrased and simplified – instead of providing predetermined categories that the participants could check, the question was transformed to being open ended, with a description of 'job tasks' to facilitate understanding.
Questionnaire too long	The Levenson Locus of Control Scales (58 items) included in the pilot questionnaire were removed and replaced with a single item that had previously been validated. The job task question was simplified.
Lack of ability to comment on two jobs	Questions regarding job profiles, characteristics and the psychosocial environment, as well as the responses to these (job satisfaction) were repeated for a second job. Qualtrics ® (2018) branching ensured that only those with more than one job were presented with the second (repeated) set of questions. General questions about demographics, dispositional traits and general biopsychosocial health were not repeated.

3.5.2.7 Data handling.

Responses were recorded on the Qualtrics ® platform, with the collected data password protected and GDPR compliant (Qualtrics ® 2018). The survey was accessed by the researcher only, on a university provided laptop. Once the survey had been closed, data was exported to the Statistical Package for the Social Sciences 24 package (SPSS24, IBM Corp., 2016). Identifying information was removed from the main data set and saved in a separate document. The laptop was password protected and stored in a locked cabinet, in a room with restricted access on campus. When campus was closed at the start of the Coronavirus pandemic, the laptop was moved to the researcher’s home address and stored in a locked cabinet there. The laptop was only accessed by the researcher. Data was backed up on the researcher’s university-based OneDrive account (the internet-based storage platform to which BCU subscribes).

3.5.2.8 Data cleaning.

The first step, prior to analysis, was to prepare the data. Participants who did not complete any of the outcome scales were removed from the sample, as were those who were not working clinically (i.e., did not carry caseloads). A flowchart depicting this process is included in Chapter Four (results).

The final sample size was comprised of complete and usable surveys from 632 participants. Each participant was allocated an identification number (ID1-ID632) and for these participants, a protocol for dealing with missing data was applied. This protocol required the replacement of missing values in outcome scales with the mean:

1. For job satisfaction (the GJSS), the mean score across all completed items was computed and used to replace missing responses. The same procedure was used with those who had selected the ‘not applicable’ option on any item – these responses were treated in the same way as missing responses.
2. For stress symptoms and mental impact (the SLPSI and the GHQ-28 respectively) the mean score for each subscale, using completed items, was calculated. Missing values in particular subscales were then replaced with the mean for that subscale.

For some variables e.g., date of birth; year qualified; or number of children cared for at home, it was not appropriate to use a mean to replace a missing value. If values were missing for these variables, they were left blank, reducing the number of participants included for analysis.

3.5.2.9 Analytic strategy: Descriptive analysis

Frequency counts, mean scores and standard deviations were used to establish distribution and central tendency for all variables.

Participants were then categorised according to the job classification described in the JDCS model (Karasek, 1979; Johnson & Hall, 1988). The SLPSI subscale ‘Time and Workload Management’ (TWM) represented demand. Because the questions on both the ‘Bureaucratic Restrictions’ (BR) and ‘Instructional Limitations’ (IL) subscales pertained to control, a new variable containing all items from these two subscales was created and named ‘Professional Autonomy’ (PA). PA represented control and the ‘Lack of Professional Support’ (LPS) subscale represented support. The following procedure was followed:

i. Subscales were dichotomised in order to yield a ‘low’ or ‘high’ score. For each participant, the mean subscale score was transformed as follows:
ii. The higher the score on the TWM subscale, the higher the demand experienced. Therefore, a mean subscale score of 1.00-3.00 was labelled ‘low’ and a mean score of 3.01-5.00 was labelled ‘high.’
iii. For the PA and LPS subscales, a higher mean score represented less control or less support respectively. Therefore, for the autonomy variable (PA subscale) and the support variable (LPS subscale), a mean score of 1.00-3.00 was labelled ‘high’ and a mean score of 3.01-5.00 was labelled ‘low.’

Participants were categorised according to the eight groups specified on the JDCS model, detailed in Table 3.2, and distribution across the eight job types (percentage of participants in each type) was described for the whole sample.

Table 3.2. The eight job types, according to the JCDS model

Job Type	Demand (TWM)	Control (PA)	Support (LPS)
Active collective	High	High	High
High-strain collective	High	Low	High
Low-strain collective	Low	High	High
Passive collective	Low	Low	High
Active Isolated	High	High	Low
IsoStrain	High	Low	Low
Low-strain Isolated	Low	High	Low
Passive Isolated	Low	Low	Low

3.5.2.10 Analytic strategy: Inferential analysis.

For all of the analysis, constructs were operationalized as follows:

i. Predictor (contributor) variables:
   a. Job types were classified according to the JDCS categories, as described in Section 3.5.2.9
   b. Factors within the biopsychosocial work environment (potential stressors) were measured using the SLPSI ‘Sources of Stress’ subscales

ii. Mediator variables:
   a. Individual differences were measured through the use of single items to evaluate self-esteem, self-efficacy, negative affect, locus of control and optimism

iii. Outcome variables:
   a. Occupational stress was measured by the two SLPSI ‘Manifestations of stress’ subscales
   b. Happiness at work and whether the job was worthwhile were measured using single items
   c. Occupational well-being was operationalised as job satisfaction and measured by the GJSS
   d. General biopsychosocial well-being was measured by the GHQ-28

Inferential analysis was as follows:

a. Scores on the SLPSI were compared to the original cohort on which the scale was developed (Fimian, et al., 1991), using a single sample t test.
b. The well-being of participants across the different JDCS job types was compared, using a one-way multivariate analysis of variance (MANOVA). At this stage, four of the groups (Passive Collective, Passive Isolated, Low-strain Isolated and Active Isolated) were eliminated from further analysis, due to small numbers.
c. The relationship between factors within the biopsychosocial work environment (demands, control and support) and well-being outcomes were investigated through correlation analysis.
d. Hierarchical multiple regression was used to examine the extent to which factors within the biopsychosocial work environment predicted job satisfaction and general biopsychosocial well-being. Both additive and interactive effects of the contributor variables were considered. Because the contributor variables (SLPSI 'Sources of Stress' subscales) were measured using multi-item scales, individual items from the scales that statistically significantly predicted outcomes were further analysed using multiple regression analysis. Multiple regression analysis was also conducted to determine which of the subscales on the GHQ-28 could be predicted by contributor variables.
e. Mediation analysis was performed to ascertain firstly whether JDCS job type affected individual differences (self-esteem, self-efficacy, locus of control, negative affect and optimism). Whether individual differences affected job satisfaction was then analysed, and finally whether individual differences explained the relationship between JDCS job type and job satisfaction was examined.
f. MANOVA was used to compare the job types, occupational stress, job satisfaction and general biopsychosocial well-being of participants who worked in different sectors (employed/self-employed/a combination of the two).
g. If any assumptions for conducting statistical tests were violated, procedures for dealing with violations were followed. These are reported in Appendix C16i-x.

3.5.2.11 Qualitative data analysis.

The survey contained two questions that elicited qualitative data.

Job tasks.

One question asked participants to list the five things that they spent most of their time on at work. They were invited to include any task that they performed as part of their job(s). Some examples were provided, but respondents were not limited to using these examples. Participants were asked to estimate the percentage of time spent on each task. On reflection, the design of this item meant that answers to the question posed a problem for analysis. This was because some respondents included different tasks together, and not all participants grouped tasks in the same way. Examples included the combination of clinically-related work with general administration – which were separated by others e.g. one respondent listed ‘planning sessions’ and ‘admin’ as separate, another listed ‘writing up notes and admin’ as a single task. While it was possible to separate tasks that participants listed together into discrete categories, it was not possible to allocate specific time spent on each of those separated tasks. Analysis was therefore limited to quantitative reporting of how much time participants spent engaged in face-to-face client content, with examples provided of other tasks that SLTs were responsible for.

Additional information.

The last item on the questionnaire asked participants whether there was anything else that they would like to say. Qualitative content analysis (Mayring, 2004) was used to examine responses to this open-ended question. Qualitative content analysis goes beyond traditional summative analysis (counting of key words); and aims to classify text according to both “explicit and inferred communication” (Hsieh & Shannon, 2005, p1278). It therefore includes both directed content analysis and inductive analysis, both utilized in the current study and further described in the following section. Analysis followed the phases suggested by Elo and Kyngäs (2008). To ensure trustworthiness, the steps followed are now described in more detail:

i. Preparation of the data: The data was read and then re-read, to enable the researcher to become immersed within it and start to make sense of it. To ensure transparency and support the credibility of claims, the unit of analysis selected was not limited to words, but included phrases, sentences and/or paragraphs.

ii. Organisation of the data: Because coding categories could be informed by prior research, a directed (deductive) content analysis was performed. First, key concepts from the literature were identified and used as categories. Secondly, the text was re-read and words, phrases or passages that, on initial impression represented existing categories, were highlighted. Next, highlighted text was categorized into the pre-selected codes. Then new codes were created, where text could not be organized using the initial coding scheme (Hsieh & Shannon, 2005). This inductive step allowed the researcher to remain open to new information that did not fit in to pre-determined themes. Finally, codes were reviewed, with similar categories being grouped together into main themes and subthemes being established.

Reflection.

A reflexive diary was commenced after the qualitative analysis of the final questionnaire item, with the aim of facilitating bracketing (which will be fully described in Section 3.6.5.3). It was created on the researcher's laptop. Excerpts from the reflexive diary are presented in Appendix C17.

3.5.3 Survey at time point two (T2).

A second, shorter questionnaire was generated following completion of Study 1.

3.5.3.1 Purpose of the longitudinal study.

Job satisfaction and general biopsychosocial well-being were measured at two points in time, the aim being to establish consistency or change, and to ameliorate the effects of reporting bias and common method variance, including mood of participants on the day (Siegrist et al., 2004) i.e., to minimise the risk of answers reflecting a transient psychological state. In an endeavour to explore whether responses about a job were consistent over time, an effort was made to ensure that participants were in the same job at T2 as they had been at T1. The time period between questionnaires being sent out to

participants was therefore set at three months. Participants were able to indicate whether any significant changes had taken place over the three months. Specifically, the aims of the second survey were to:

a. Measure job satisfaction, to ascertain whether there were any changes that had occurred since the first survey.
b. Measure general biopsychosocial well-being, to determine whether any changes had occurred since the first survey.
c. Establish whether any changes in circumstances (either a different job or initiating positive personal changes in an attempt to foster well-being) had occurred since the first survey.
d. Investigate whether an association existed between any changes made and job satisfaction, or general biopsychosocial health.

3.5.3.2 Materials.

The second survey again used the Qualtrics ® (2018) platform to distribute an online questionnaire. The questionnaire was a shortened version of the one used at T1. The following changes were made:

a. The sections on demographics, working profiles, job characteristics and dispositional traits were not included.
b. The SLPSI was not included.
c. The GJSS and GHQ-28 were retained.
d. Two questions were added:
    i. *Are you still in the same job that you were in when you answered the first questionnaire between April and July 2018?* If the participant responded with ‘no’, they were given options regarding what their current position now was e.g., employed by the NHS/self-employed/not working/other.
    ii. *Have you personally made any positive personal changes that you believe have altered your well-being? (e.g., no longer taking work home/started an exercise programme etc.).* If a participant responded with ‘yes’ they were asked to say a little about the changes that they had made.

Finally, participants were once more provided with the opportunity to add any additional comments.

3.5.3.3 Procedure.

On 14 September 2018, the second questionnaire was emailed to the 480 participants who had agreed to complete a follow-up survey and provided their addresses at T1. Of these, three returned automatic messages stating that the person in question was no longer in post. A further 22 returned 'undeliverable' messages. As there was a potential that emails were rejected due to being part of a mass mailing, the researcher re-sent individual emails to these addresses, and seven participants were reached. This meant that of the 480 participants, 462 (96.3%) emails were delivered. By 2 October 2018, 235 participants had responded. A reminder email was sent to the remaining 228 people who had provided an email address but who had not yet completed the questionnaire. On 14 October, 327 (70.8%) responses had been recorded by Qualtrics ® (2018). The survey was closed at this time, having been made available for a month.

3.5.3.4 Sample size.

The process for inclusion of participants at T2 can be found in Figure 3.2.

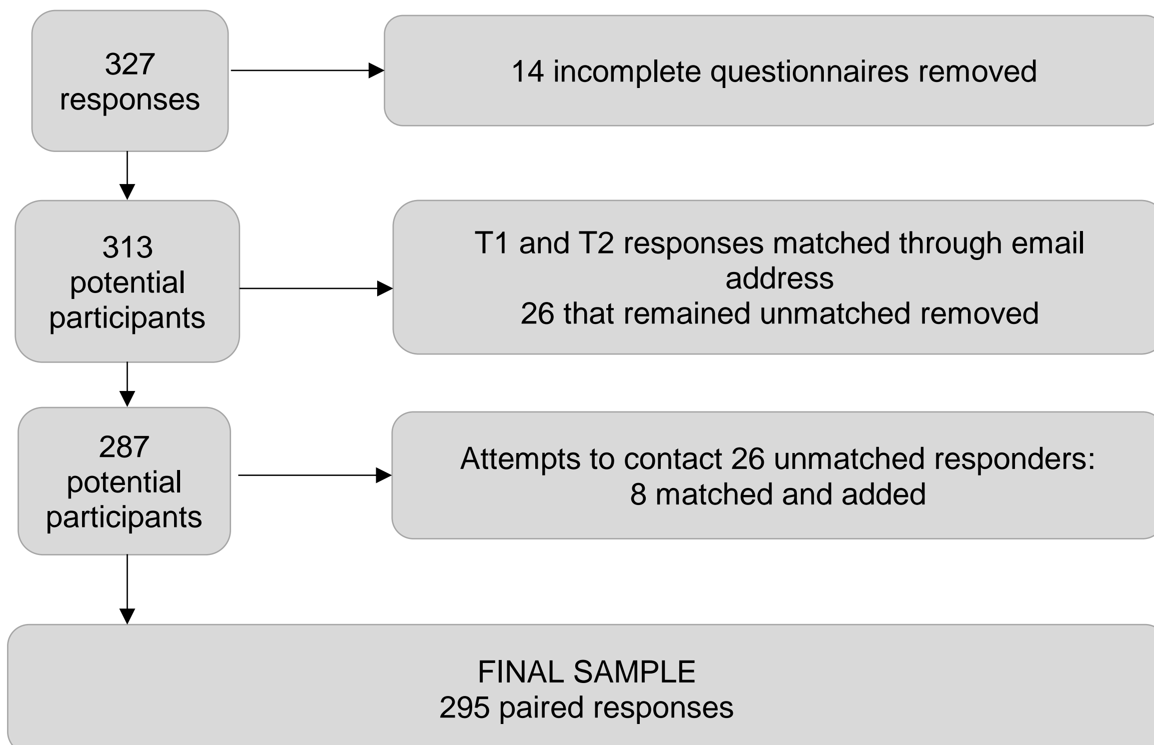

Figure 3.2. Flowchart of the inclusion of participants at T2

3.5.3.5 Quantitative data analysis.

Descriptive analysis.

Outcome measures of job satisfaction and general biopsychosocial well-being were subject to frequency, means and standard deviation calculations. Frequency counts were also used to describe reported changes in personal status (i.e., either having left the job that the participant had held at T1 or having introduced a significant 'positive personal change').

Inferential analysis.

Outcomes measured at T2 were compared to those from T1 for the whole sample, using t-tests. A three-way mixed MANOVA was conducted to compare the outcomes of four different groups within the sample, i.e., those who had:

i. Stayed in their job and made no 'positive personal change'
ii. Stayed in their job but made a 'positive personal change'
iii. Left their job but made no 'personal change'
iv. Left their job *and* made a 'positive personal change'

3.5.3.6 Qualitative data analysis.

Participants were asked to provide details of positive personal changes that they had made since T1, through an open-ended question. Content analysis was used to analyse the information that was provided. Following this, an entry was made in the researcher's reflexive diary (Appendix C17).

3.6 Phase Two: The Idiographic Phase – A Round of Interviews

3.6.1 Overview.

The second phase of the research adopted a hermeneutic phenomenological approach. Hermeneutics within the social sciences involves interpretation of experiences (Anderson, Sharrock, & Hughes, 1986). It includes the analysis, by the researcher, of interpretative acts, and richness of interpretation is considered more valuable than arriving at a 'correct' interpretation. Phenomenology focuses on the nature of immediate conscious experience

(APA Dictionary of Psychology, 2020). Fifteen semi-structured interviews took place, aiming to build upon the first phase of the research by further describing UK SLTs' work experiences and investigating their views around biopsychosocial well-being. Interpretative phenomenological analysis (IPA) facilitated this investigation. This idiographic element of the project allowed for scrutiny of the particular through in-depth analysis, acknowledging the perspective of individuals within specific contexts (Smith, et al., 2009). An emic viewpoint (Fetterman, 2008) was applied, by assuming that the understanding of constructs studied necessitated definition from within the population being studied.

3.6.2 Study Design.

3.6.2.1 Methodological orientation: Interpretative Phenomenological Analysis (IPA).

This study utilised interpretative phenomenological analysis (IPA) to examine the qualitative data collected. IPA has strong philosophical underpinnings, sharing some of the fundamental elements of pragmatism. Both are concerned with experience, and the analysis of the lifeworld (Hitzler & Eberle, 2004). James's pragmatism places the role of experience as central to the creation of individual 'truths', or 'realities' (Bertman, 2007), while for Husserl, phenomenological inquiry focuses on 'that which is experienced in the consciousness of the individual' (Smith, et al., 2009, p13). IPA is concerned with 'making meaning', it is focused on seeking the 'essence' of experience; that is on making sense of the 'lived experience'. The three major theoretical underpinnings of IPA include phenomenology, hermeneutics and idiography (Smith, et al., 2009).

Firstly, IPA is phenomenological in nature. Phenomenology – the study of that which appears – is realized within IPA through the examination of what experiences are 'like', with particular emphasis on those elements of lives that are important to people, that constitute 'lived experiences' (Smith, et al., 2009). IPA is a reflective process that attempts to understand the lived experience of a person as an embodied individual in the context of the world and in relation to others, and who is continually developing, or 'becoming themselves.' Secondly, interpretation – or hermeneutics – is important in IPA. Analysis embraces both the double hermeneutic, where the participant interprets their experience and the researcher then interprets the information provided by the participant, and the hermeneutic loop – understanding of the whole through its constituent parts and the parts

in terms of their relationship to the whole. The double hermeneutic acknowledges that the researcher's ability to 'bracket' their own preconceptions is only party achievable. Finally, IPA has an idiographic focus, i.e., it is concerned with the particular, requiring in-depth analysis that is committed to understanding the perspective of 'particular people, in a particular context' (Smith, et al, 2009, p29). Brief commentary on the theoretical foundations of IPA, including the contributions of Husserl, Schleiemacher, Heiddeger, and Gadamer, is detailed in Appendix C18.

IPA has successfully been used to explore health and well-being at work generally and more specifically in the public sector (e.g., Sallis & Burkin, 2014) and with health professionals (e.g., Lamb and Cogan, 2015; Volpato, Banfi, Valota and Pagnini, 2018).

3.6.3 Participants.

3.6.3.1 Sampling strategy.

A typical case purposive sampling strategy (Onwuegbuzi & Collins, 2017) was used to establish the sample parameters. Purposive sampling was used specifically to further elucidate particular areas of interest and specific experiences. This enabled additional investigation and explanation of insights that had emerged from the questionnaire data (Morgan 2014).

The second phase of the study aimed to explain and expand upon the quantitative findings by capturing the perceptions of participants, based on their experiences at work. Therefore, the variables of interest identified during Phase One analysis informed participant selection for Phase Two.

3.6.3.2 Sample size.

The use of IPA determined the target sample size. IPA constitutes an idiographic methodology which necessitates both a case-study like approach to develop themes identified in data from individuals, followed by comparison between cases to draw out patterns across the data set. The target group size of 15 aimed to allow a multi-perspectival analysis (i.e., including views from SLTs from employment sectors). Participants who completed the first questionnaire during Phase One of the project, were asked whether

they would be willing to take part in an interview at a later date. Of the 632 respondents, 48% of clinicians (n=303) indicated that they were happy to be interviewed.

3.6.3.3 Recruitment.

In January 2019, potential participants who had indicated that they were willing to be contacted to participate in a follow-up interview, and who met the inclusion criteria established following Phase One, were contacted by email or by telephone (for those who had not provided email addresses). A total of 25 potential participants (15 who were employed and 10 who were self-employed) were contacted. Due to the small percentage of men who had agreed to be interviewed, all (n=4) were contacted. Of the SLTs who were contacted:

- Two of the email addresses returned ‘undeliverable’ notices (both were men)
- Seven did not reply to messages (this included the other two men, both of whom did not respond to a second attempt at contact)
- Sixteen (10 who were employed and six who were self-employed) stated that they were still interested

Liaison then took place with the 16 SLTs who were still interested; and a mutually convenient date and time for the interviews and venues was agreed. At this point, one independent SLT was omitted as it was not possible to find a mutually convenient date for an interview. Participants chose the venues for their interviews, and the information sheet and data protection forms were sent to the fifteen remaining SLTs, via email.

3.6.4 Setting of data collection: geographical location and venue.

Selecting the location for the interviews went beyond practicality, or the notion of convenience. By enabling the interviewee to participate in the selection of the interview location, the researcher demonstrated flexibility and willingness to adapt, thus facilitating democratization of the process and a sharing of ‘power’. Through this negotiation, each participant became a partner in structuring the event and thus in the creation of knowledge (Hertzog, 2005). Consideration of location which enabled interviewees to participate in the decision-making process supported the philosophy underpinning this project in that it acknowledged the importance of power and place, conceptualized within critical reflections

on methodology (Elwood & Martin, 2000). This stance resulted in interviews taking place across the ten geographical regions that participants worked in.

3.6.5.1 Geographical location of interviews.

At T1, the only geographical information gathered was whether participants worked in England, Scotland, Northern Ireland or Wales. Therefore, it was not possible to select interviewees according to specific regions, apart from their home nation. The fifteen participants who were interviewed represented a range of geographical locations, as shown in Table 3.3. Practical considerations, including a lack of time and limited funding, did not allow for the researcher to travel to Northern Ireland.

Table 3.3. Geographical location of interview participants

Location	Number of participants
England	
South West	1
South East	1
London	3
East Midlands	3
West Midlands	2
North West	1
Northumberland	1
Yorkshire and the Humber	1
Scotland	1
Wales	1

3.6.5.2 Venues for interviews.

The researcher travelled to venues selected by the interviewees. Seven of the participants elected to be interviewed in their homes. Two chose their places of work and booked a private room. Five selected coffee shops and one a restaurant. Participants sent details of venues to the researcher. As approved by the BCU BLSS FREC, the researcher shared venue details, and dates and times of interviews, with their Director of Studies (DoS) prior to the interviews taking place. Before and after each interview a text message was sent to

the DoS and the researcher kept a charged mobile phone with them at all times. Following the interviews, the DoS destroyed the documents containing venue details.

3.6.5 The Interviewer and Reflexivity.

3.6.5.1 Personal characteristics.

The interviews were conducted by the researcher, a female SLT, who at the time was a PhD student. She had 27 years' experience as an SLT, working with children in mainstream primary schools. While not having prior training or experience interviewing research participants, she had experience of listening to service-user stories as part of case history taking in her clinical role.

3.6.5.2 Relationship with participants.

A relationship with participants was not established prior to study commencement. However, when potential participants were contacted, they were informed that the researcher was an SLT. The researcher also provided her reasons for conducting this phase of the research. Finally, an attempt at initial rapport building was made through 'small talk' on the telephone when arranging an interview.

As an SLT investigating the work characteristics and well-being of SLTs, the investigator was, for this project, an insider researcher. Being an insider comes with presuppositions about the area being explored. The researcher's interest in the research topic arose due to her own experiences of work-related stress. In addition, conversations with her colleagues over the years suggested that others also experienced stress. She was aware of potential assumptions that she might therefore make about participants. These assumptions, which stemmed from her own experience, included:

i. SLTs – particularly those working in mainstream schools – have stressful jobs
ii. High caseloads are a cause of stress
iii. SLTs can feel undervalued

She was conscious of the need to bracket these presuppositions.

3.6.5.3 Bracketing.

A conscious attempt was made to minimize bias stemming from personal views by bracketing these views and feelings prior to, during and after the interviews. This was achieved through the use of a reflexive diary to acknowledge and foreground the researcher's presuppositions (Tufford & Newman, 2010), while recognising that bracketing can only ever be partly achieved (Smith et al., 2009).

Entries in the reflexive diary (excerpts in Appendix C17) were made following the completion of Phase One, and before the commencement of the interviews. Entries were also made throughout the interview stage and specifically after each interview, and again after analysis of the data from each interview.

3.6.6 Description of the sample.

There were some changes to employers in the time period between participants consenting to be interviewed in Phase One and the interviews taking place. Two who had been working for the NHS had resigned: one had left the career and one had left the NHS and was intending to set up an independent practice. One person who had been working in the third sector (for a charity) had moved to the NHS. Table 3.4 provides details of the participants who were interviewed.

Table 3.4. Details of participants who were interviewed

Pseudonym	Geographical location	Age	Year qualified	Client group (caseload size)	GHQ total	Caseness?	FT/PT (days per week)	Employment type
Kathryn	East Midlands	47	1992	Adult community (n=17)	36	Y	PT (3)	Organizationally employed: 3rd sector – Social Enterprise (providing services to the NHS)
Gwenneth	Scotland	50	1989	Paediatric (n=50)	24	Y	FT	Organizationally employed: NHS
Pamela	West Midlands	55	1987	Adults with Learning Difficulties (n=12)	64	Y	FT	Organizationally employed: NHS
Hendre	Wales	59	1981	Adult community (n=45)	34	Y	PT (3)	Organizationally employed: NHS

Anne	Northumberland	47	1994	Paediatric community (n=55)	26	Y	FT	Organizationally employed: NHS
Jo	East Midlands	42	2005	Adult (ward) (n=9)	26	Y	PT (3)	Organizationally employed: NHS
Jan	East Midlands	24	2016	Adult community (n=26)	35	Y	FT	Organizationally employed: NHS
Susan	London	35	2014	Paediatric pre-school (n=51)	61	Y	FT	Organizationally employed: NHS
Carol	North West	54	1991	Paediatric: Child Development Clinic (n=132)	41	Y	FT	Ex NHS (left the career between the time of the survey and the time of the interview)
Alice	Yorkshire & the Humber	43	1999	Adult community (n=80)	58	Y	PT (3)	Ex NHS (currently not working – about to start as a sole trader)

Isabella	London	42	2008	Paediatric Schools (n=132)	22	N	FT	Self-employed: working through an umbrella company
Sally	South East	40	1999	Paediatric: Schools (n=23)	19	N	PT (4.5)	Self-employed: part sole trader & part working for an independent practice
Willow	South West	47	1997	Adult community (n=10)	11	N	FT	Self-employed: sole trader
Ruby	London	48	1993	Paediatric Schools (n=30)	22	N	FT	Self-employed: sole trader
Lesley	West Midlands	47	1993	Paediatric Schools (n=25)	9	N	FT	Self-employed: sole trader

3.6.7 Data collection.

3.6.7.1 Materials: the interview schedule.

Information gained from Phase One of the project informed the design of the interview schedule (Appendix C19). The explanatory design of the study, described in Section 3.3.1, meant that items in the schedule were devised with the aim of achieving a fuller understanding of the occupational and general biopsychosocial well-being of SLTs and the way that different factors in the work environment influenced their well-being. It was hoped that this understanding would be enhanced through an analysis of the experiences of participants. Because questions were devised using the data that participants provided during Phase One, and not driven by theory, inductive analysis was possible.

3.6.7.2 Pilot Study.

A single pilot interview was held in a public space (a coffee shop) in December 2018. The aim of the pilot interview was to check that questions made sense to participants, flowed well, and were understood by interviewees. A further aim was to assess the quality of recording made in a public space. The participant for the pilot interview was selected from the list of respondents to the first questionnaire who had agreed they would be willing to be interviewed.

During the interview, the pilot participant became distressed and started crying. When asked whether she wanted to stop or have a break she stated that she was ‘okay’ and that she was ‘fine to continue’. After the interview she expressed surprise that she had become upset, stating that she hadn’t expected to, but that recounting unpleasant experiences had resulted in negative feelings resurfacing. She acknowledged that the risk of upset was made clear in the participant information sheet, but suggested that, in addition to this, the researcher verbally alert interviewees to this possibility before commencing the interview. This suggestion was incorporated in the interviews that followed.

Following the interview, the pilot participant also provided verbal feedback about the questions asked. She stated that questions made sense in terms of the purpose of the project and were not difficult to understand and that the interview felt ‘natural’. She did not feel that any questions needed to be changed.

The audio quality of the recording was of a standard that allowed comfortable transcription. The pilot participant was sent a summary transcript of the interview so that she could check it for accuracy. However, she did not reply to the email that was sent.

3.6.7.3 Procedure.

The interview technique.

The researcher conducted all the interviews. Before starting, participants were thanked for agreeing to be interviewed and asked whether they had any questions about the information sheet that had been sent via email. No participants had any queries at this point. Consent was discussed, including confirming permission to record the interview; and participants signed the consent form (Appendix C7). They also provided a pseudonym to ensure anonymity. An explanation of how recordings would be managed following the interview was provided and participants were asked whether they would like to be placed on a mailing list to receive notifications of any dissemination of findings. All interviewees stated that they would like to be on the mailing list. Participants were reminded that there were no right or wrong answers, and that they were not expected to represent their profession or their colleagues. They were also reminded that it was possible that talking about experiences might cause distress and that they did not have to answer questions should they not wish to, and that they could pause, or stop the interview, should they want to. The interview then proceeded, using the schedule.

Interviews were semi-structured. Every topic was covered with every participant, but the researcher attempted to be flexible in the way that questions were asked, and the order in which they were asked. If particular topics or ideas were raised, these were followed up. For example, one participant (Lesley) began, almost immediately, by talking about control so this topic was explored early on. Another (Kathryn) specifically discussed resilience, and this area was therefore probed.

After the interviews, the participants were again thanked. They were debriefed (Appendix C20) and informed that a summary of the interview would be sent to them so that they could check accuracy of the researcher's understanding. Finally, they were asked whether it would be possible to contact them if further questions from the interview arose. Interviews were planned to be approximately 60 minutes long, and most were around this length. The shortest one was 51min long, and the longest was 95 minutes. Brief field notes were made

after each interview, to provide an aide-mémoire for writing entries in the reflexive diary, which were completed once the researcher was back on campus.

Data Handling.

Interviews were recorded using a Sony ICD-PX370 Digital Voice Recorder. Recordings were transferred to a password-protected laptop as soon as possible and backed up on the university-based OneDrive account. Once this had been done, the recordings on the Dictaphone were deleted. Following the transfer of all 15 voice recordings to the laptop, the researcher transcribed them using Express Scribe Transcription software and a VEC Infinity IN-USB-2 foot peddle. Transcription was conducted over a period of four weeks and completed transcriptions were also stored on the password-protected laptop as soon as possible and backed up on the university-based OneDrive account.

Transcription.

Using conventional IPA transcription (Smith, et al., 2009), all words spoken, laughter, and pauses were transcribed from the audio recordings. Pseudonyms provided by participants were used on transcripts, and if locations were mentioned by participants, they were anonymized. No participants mentioned the names of third parties, and two asked for possible identifying descriptions of managers (e.g., a nickname) to be removed prior to analysis. Transcripts were double spaced, and lines numbered. Large margins to allow space for initial notes on the data were used. Transcripts were then printed to allow for initial analysis.

Quality checking.

After transcribing all 15 audio recordings, each transcript was read to create a summary of the interview. The summaries were then sent to the interviewees via email for participant checking. Only one participant requested a change, asking for part of the interview not to be used. The researcher felt that omission of the specific incident that the participant felt would threaten anonymity if included, would not detract from a reader's ability to access the participant's experience and feelings. The participant was happy for the rest of the interview to be used. Of the remaining 14 interviewees, 12 replied to emails stating that they agreed with the content of the summaries. A second email was sent to the two who did not reply, but no responses were received. This was taken as an indication that the

participants either did not wish to; or did not have the capacity (e.g., time) to provide feedback.

3.6.8 Qualitative data analysis.

The researcher analysed the qualitative data using IPA. IPA requires a case-by-case analysis. Of the six steps to analysis, recommended by Smith, et al. (2009), the first four pertain to one case, after which the steps are repeated for the next cases. Finally, patterns across cases are identified. The six steps, detailed below, were followed:

Step 1: Reading and re-reading

The initial step allowed the researcher to immerse herself within the data and ensure that the participant was the focus of analysis. This process of immersion began with the researcher transcribing the interview, which meant that the voice of the participant was at the forefront of the analysis. Following transcription, the transcript was read once in order to create a summary for participant checking, and then a second time, when initial observations were made in the margins of each transcript.

Step 2: Initial noting

The transcript was read for a third time, and further notes were made in the margins. The third reading allowed for initial observations to be fleshed out, and categorised into descriptive, linguistic and conceptual comments, using colour coding. During this step anything of interest was noted. Similarities and differences, echoes, amplification and contradictions within the transcript were recorded, and the early identification of themes took place. An example of an excerpt from an annotated transcript is presented in Appendix C21.

Step 3: Developing emergent themes

This step involved focusing on the larger data set for the individual participant i.e., the individual transcript *and* notes pertaining to that transcript. At this point, following the hermeneutic circle, the narrative of the interview was dissected, to allow for focus on the parts of the whole. Notes were transformed into more concise statements that reflected comments about various sections of the transcript and formed the initial collection of possible themes. Emerging themes included enough particularity to be grounded in data, but also began to reflect more abstract constructs (Smith, et al., 2009).

Step 4: Searching for connections across emergent themes

Initially, the emerging themes in a transcript were noted in the chronological order in which they'd appeared. Some themes were discarded, and other themes were drawn together to enable the most interesting and important aspects of a participant's account to be identified and prioritised. This step was achieved by grouping concepts that were theoretically related into themes and then assigning these to overarching (or superordinate) themes.

Step 5: Moving to the next case

The researcher made a concerted effort to bracket ideas that had emerged from the first case before moving to the next, and with subsequent cases. This was achieved by having a break from analysis, by referring back to the research diary in order to focus specifically on the participant, and by keeping an open mind about what the analysis might yield. The researcher was also aware that she would be influenced by what she had already found, i.e., a change in her fore-structures would have taken place. Step 5 consists of moving to the next participant, and repeating Steps 1 to 4.

Before Step 6, the three members of the supervisory team performed initial coding on three of the transcripts (each supervisor scrutinized a different transcript). Subsequent to this, the researcher met each supervisor individually, to compare and agree codes. In all three cases, codes generated by the researcher aligned with those produced by the supervisor.

Step 6: Looking for patterns across cases

Following analysis of each individual case, the final step was to identify patterns across the data set. The summary of themes for each participant, along with supporting quotes, was printed. This allowed quotes and notes to be physically moved around. The data was searched for the most potent themes, for connections between the cases, and for themes present in one case being illuminated by a different case. Some themes needed to be reconfigured and relabelled as the analysis progressed. At this point, the analysis moved to a more theoretical level by linking relevant theory more closely to the participants' recounts of their experiences. An attempt was made to represent the way participants represented unique viewpoints, but also shared higher order qualities.

Interpretation occurred at three levels:

i. Verbal content
ii. Language used e.g., metaphor, conscious and unconscious repetition, specific vocabulary
iii. Analysis of suprasegmental elements (e.g., stress and intonation) and non-verbal aspects (e.g., pausing, laughter)

After initial patterns had been identified across the first five cases, it became apparent that using paper was a cumbersome method of working with the data. Therefore, at this stage, use was made of the NVivo 12 qualitative data analysis software package (NVivo12, QSR International, 2018) to improve the ease of moving quotes and notes, and of reconfiguring and renaming themes if necessary.

3.6.9 Rigour.

Rigour in qualitative research includes credibility, transferability, dependability and confirmability (Lincoln & Guba, 1991). Cypress (2017) argues that these terms are synonymous with reliability, validity and generalizability. During this study, rigour was built into the qualitative phase, from design through to data gathering, analysis and presentation of information. Credibility may be threatened by the researcher as 'sole instrument' - Yardley and Bishop (2017) recommend five methods to enhance validity, and these are described in Table 3.5, along with how these methods were used in the current study. Furthermore, the relevance of findings to the field was considered. These features of the project aimed to promote the authenticity of the research.

3.7 Design for methodological integration.

Mixed methods research requires that planning consider at which points throughout the project integration occurs. Table 3.6 provides a visual representation of the research design, based on Bazeley's (2018) model, including the specific points of integration.

Table 3.5. Methods to enhance study validity

Recommendations	This study
The study should be informed by in-depth knowledge of context.	An extensive literature review framed the extant knowledge and highlighted gaps, which informed the planning of the study. Although there was limited qualitative research that investigated SLT well-being, other theoretically relevant research was also read e.g., the use of IPA to investigate the 'lived experiences' of other populations. In addition, the researcher is an experienced SLT, providing her with knowledge of context.
The sample should represent a range of people whose views and experience are important to fully understand the phenomenon.	A purposive sample included SLTs with experience of the phenomenon under investigation i.e., practising clinically in the UK, and who met the inclusion and exclusion criteria.
Possible influences of the researcher (as 'sole instrument') on the data generated should be reflexively considered.	A reflexive diary was maintained to facilitate awareness of assumptions held and possible bias in interpretation. This was particularly important due to the position of the researcher as an insider. The influence that this might have on interactions was considered. Bracketing was applied throughout the phase.
External validity should be maximized e.g., interview schedule should not constrain responses.	The interview schedule was developed with guidance from the researcher's supervisors to ensure that it allowed participant responses that were not biased e.g., through leading questions. A committed attempt was made to ensure that interviewees were not given cause to construct a specific (biased) version of their experiences which did not correspond with their views.
In-depth analysis should be carried out, using rigorous, transparent procedures.	The method of analysis (IPA) was carefully selected and applied and the six steps to IPA were closely followed. The researcher's interpretations were empirically grounded in those of the participants, and an audit trail was kept, providing evidence for interpretations. Interpretations were checked by the researcher's supervisors.

Table 3.6. Integrated study design & data analysis (template from Bazeley, 2018)

Specific research objective	Theoretical/ conceptual basis	Data sources ***(integration of design throughout, requiring collection of both quantitative and qualitative data)***	Data analysis
Research question 1: What is the occupational well-being of SLTs currently working clinically in the UK?			
To describe the current psychosocial work environment (operationalised as demand, control and support) of SLTs practising clinically in the UK	JDCS model (Karasek, Johnson & Hall) UK specific application (HSE, Black) Hermeneutic phenomenology (Husserl, Heidegger, Gadamer)	• Cross-sectional quantitative and qualitative data from survey (Phase 1, T1)* • Qualitative data from interviews (Phase 2)	Descriptive statistics (M, SD) Qualitative content analysis (open-ended question at T1) Interpretative phenomenological analysis (IPA) ***Analysis integration point: data from phase 1 & phase 2 both contributed to objective***
****Mixed Methods design integration point: information gained from quantitative analysis & qualitative content analysis (Phase 1, T1) informed the design of questions for interview (Phase 2)***			
To apply the JDCS model to the data, to classify jobs held by participants	JDCS model (Karasek, Johnson & Hall)	• Cross-sectional quantitative data from survey (Phase 1, T1)*	Descriptive statistics ***Include conversion of quantitative (scale) data to qualitative descriptors (JDCS job types)***

To investigate the meaning that SLTs give to their work experiences and well-being	Biopsychosocial model (Engel) Hermeneutic phenomenology (Husserl, Heidegger, Gadamer)	• Qualitative data from interviews (Phase 2)	IPA: Within and across case analysis ***Analysis <u>integration point</u>: relate interview findings to content analysis from phase 1, T1 & T2, and to quantitative findings from T1 & T2***
To explore the occupational well-being of SLTs, operationalised as job satisfaction	Psychosocial well-being & the Biopsychosocial model (Engel) Job satisfaction & stress theory (Cooper, Lazarus & Folkman)	• Quantitative data from longitudinal survey (Phase 1, T1 & T2) • Qualitative data from T2	Descriptive statistics Compare with other SLT data (independent t-test) Compare T1 to T2: ascertain changes in well-being (MANOVA) Content analysis (open-ended question at T2) ***Analysis <u>integration point</u>: data from phase 1 quantitative & qualitative findings***

To examine the additive effects of job demands, control and support on job satisfaction	JDCS (Karasek, Johnson & Hall) Psychosocial well-being & the Biopsychosocial model (Engel) Domain specific SWB – job satisfaction (Cooper et al)	• Cross-sectional quantitative data from Phase 1, T1	Inferential statistics (correlations, multiple hierarchical regression analysis)
To establish the interactive effects of job demands, control and support on job satisfaction	JDCS (Karasek, Johnson & Hall) Psychosocial well-being & the Biopsychosocial model (Engel) Domain specific SWB – job satisfaction (Cooper et al)	• Cross-sectional quantitative data from Phase 1, T1	Inferential statistics (multiple hierarchical regression analysis)
To consider the mediating effect of individual differences on the relationship between the psychosocial work environment and occupational well-being.	Trait theory & core self-evaluations (Cooper et al, McRae & Costa, Judge et al)	• Cross-sectional quantitative data from Phase 1, T1	Descriptive statistics Inferential statistics (mediation analysis)

To compare the occupational well-being of those who are employed to those who are self-employed and to those who straddle both employment settings	Apply psychosocial well-being (Engel) and domain specific SWB – job satisfaction (Cooper et al), to different employment sectors (e.g., Schonfeld & Mazzola)	• Cross-sectional quantitative data from T1 • Qualitative data from interviews (Phase 2)	Inferential statistics – group comparisons (MANOVA) IPA ***Analysis <u>integration point</u>: data from study 1 & study 2***
Research question 2: What is the general biopsychosocial well-being of SLTs in the UK?			
To describe the general biopsychosocial well-being of SLTs, operationalised as incidence of somatic symptoms, levels of anxiety, depression, and social dysfunction.	Psychosocial well-being & the Biopsychosocial model (Engel) Hermeneutic phenomenology (Husserl, Heidegger, Gadamer)	• Quantitative data from longitudinal survey (Phase 1, T1 & T2); qualitative data from T2 • Qualitative data from interviews (Phase 2)	Descriptive statistics Compare T1 to T2: ascertain changes – personal & in employment & changes to well-being (MANOVA) Content analysis of changes – personal & in employment (open-ended question at T2) ***Include <u>conversion</u> of quantitative (scale) data to qualitative descriptors (e.g., 'caseness', 'mild distress'***

			Include transformation of qualitative data to quantitative – frequency reporting IPA ***Analysis integration point: data from phase 1 & phase 2***
To compare the general biopsychosocial well-being of those who are employed to those who are self-employed and to those who straddle both employment settings.	Application of JDCS model, psychosocial well-being & the Biopsychosocial model (Engel) to different employment sectors (e.g., Schonfeld & Mazzola)	• Cross-sectional quantitative data from phase 1, T1 • Qualitative data from interviews (Phase 2)	Inferential statistics – group comparisons (MANOVA) IPA ***Analysis integration point: data from phase 1 & phase 2***
To examine the influence of the psychosocial work environment on general biopsychosocial well-being	Psychosocial well-being & the Biopsychosocial model (Engel) Hermeneutic phenomenology (Husserl, Heidegger, Gadamer)	• Cross-sectional quantitative data from Phase 1, T1 • Qualitative data from interviews (Phase 2)	Inferential statistics (multiple hierarchical regression analysis) IPA ***Analysis integration point: data from phase 1 & phase 2***

To examine the additive effects of job demands, control and support on general biopsychosocial well-being	JDCS (Karasek, Johnson & Hall) Psychosocial well-being & the Biopsychosocial model (Engel)	• Cross-sectional quantitative data from Phase 1, T1	Inferential statistics (correlations, multiple hierarchical regression analysis)
To establish the interactive effects of job demands, control and support on general biopsychosocial well-being	JDCS (Karasek, Johnson & Hall) Psychosocial well-being & the Biopsychosocial model (Engel)	• Cross-sectional quantitative data from Phase 1, T1	Inferential statistics (multiple hierarchical regression analysis)
To explore the factors perceived by SLTs to influence their general biopsychosocial well-being	JDCS model (Karasek, Johnson & Hall) psychosocial well-being & the Biopsychosocial model (Engel)	• Qualitative data from survey (Phase 1, T1) • Qualitative data from interviews (Phase 2)	Qualitative content analysis of open-ended survey responses from Phase 1, T1 IPA ***Analysis integration point: data from phase 1 & phase 2***
MM integration point: relate comments from T1, & interview data to quantitative responses from T1 & T2			

The next chapters present the findings from both the longitudinal survey and the semi-structured interviews.

CHAPTER FOUR: THE NOMOTHETIC PHASE
DESCRIPTIVE RESULTS

4.1 Overview of the chapter

This chapter presents the descriptive results of Phase One of the study. An explanation of how the final sample size was achieved is provided, followed by information describing the demographic profile of the sample. The dispositional traits of participants, including self-esteem, generalised self-efficacy, locus of control, affect and optimism, are then summarised. Next, the employment histories, working profiles and job characteristics of the sample are outlined. The remainder of the chapter details the psychosocial work environments of participants, in terms of demand, control, and support. Finally, well-being outcomes of the sample are described, including occupational stress, job satisfaction and general biopsychosocial well-being. The chapter then concludes with a summary of key points.

4.2 Sample size

The original online survey received 863 responses from UK-based SLTs, and Figure 4.1 shows the flowchart for the inclusion process of participants.

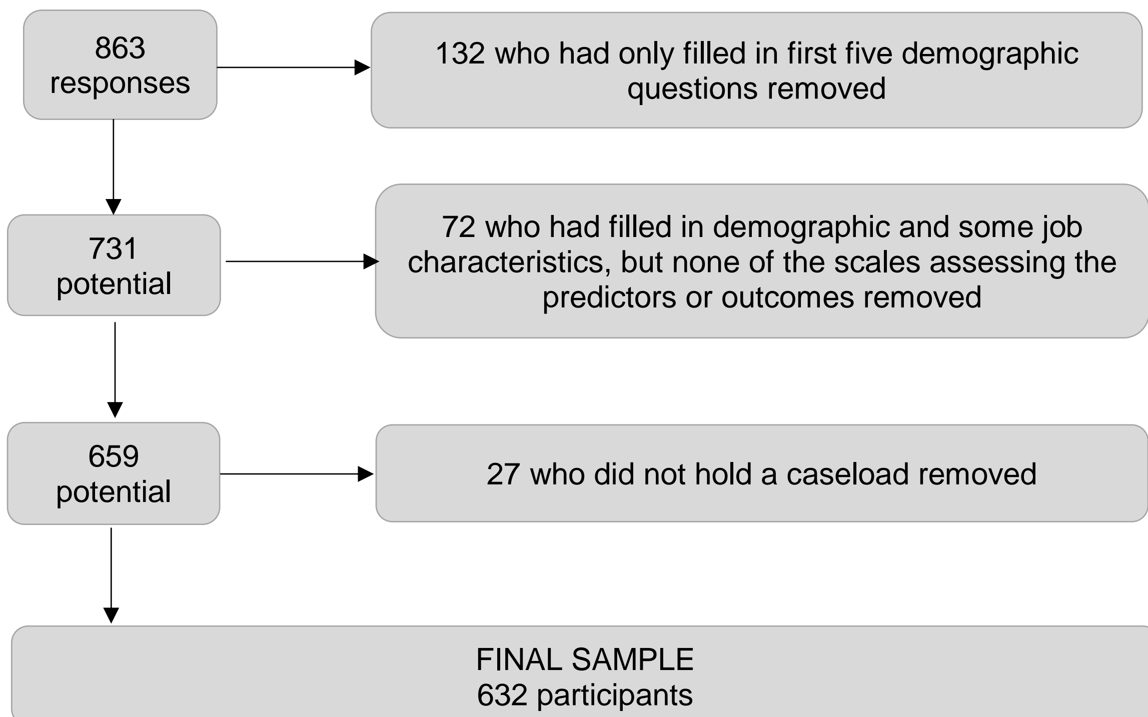

Figure 4.1. Flowchart of the inclusion process for final sample

4.3 Descriptive analysis

4.3.1 Demographic composition of participants.

4.3.1.1 Gender, Age and Ethnicity.

Of the 632 participants, 98% (618) were female and 2% (14) were male. According to the latest figures from the HCPC (February 2017), 3% of all registered SLTs are men. Distribution of the sample is therefore broadly in line with current population statistics.

The mean age of the participants was 38.7 years (SD = 10.4). The median age was 37 years, and the mode was 30, with the range from 21 years to 65 years. Table 4.1 presents a comparison of the age range of the sample, compared to data held by the HCPC, and provides evidence that the sample once again broadly reflected population statistics.

Table 4.1. Age range of sample compared to HCPC data

Age range	**Numbers of SLTs (%)**	
	This sample	**HCPC data (2017)**
20-24	32 (5.1)	714 (4.5)
25-29	109 (17.2)	2,595 (16.2)
30-34	122 (19.3)	2,939 (18.3)
35-39	87 (13.7)	2,523 (15.7)
40-44	84 (13.3)	1,986 (12.3)
45-49	69 (10.9)	1,712 (10.8)
50-54	66 (10.4)	1,609 (10.0)
55-59	41 (6.6)	1,240 (7.7)
60-64	12 (1.9)	571 (3.6)
65-69	2 (0.3)	139 (0.9)
Not reported	8 (1.3)	0 (0)
Total	**632 (100)**	**16,081 (100)**

Of the 632 participants, 95% (*n*=599) described themselves as White, and 4% (*n*=23) identified as being from Black, Asian or Minority Ethnic (BAME) communities. Neither the HCPC nor the RCSLT currently hold data on ethnicity, therefore it was not possible to determine whether the sample represents the population. Table 4.2 provides further detail of the ethnicity of participants.

Table 4.2. Ethnicity of the participants in the survey

Ethnicity	**Participants** *n (%)*
White British (English/Welsh/Scottish/Northern Irish)	540 (85.4)
White Irish	36 (5.7)
White other	23 (3.6)
Mixed race	11 (1.7)
Asian	7 (1.1)
Black	3 (0.6)
Arab	2 (0.3)
Other	2 (0.3)
Preferred not to say	8 (1.3)

4.3.1.2 Relationship Status.

The relationship status of participants is shown in Table 4.3.

Table 4.3. Relationship status

Relationship Status	**Participants** *n (%)*
Married	339 (54)
Living with partner	140 (22)
Have a partner, not living together	44 (7)
Single	79 (13)
Divorced	22 (3)
Separated	7 (1)

4.3.1.3 Number of children currently being cared for at home.

The majority of SLTs who responded to the survey (64.2%, *n*=404) were not looking after children at home at the time of the study. Of the 35.8% (*n*=228) who were looking after children at home, 116 (18.5%) looked after two children, 81 (12.9%) cared for one child, 26 (4.1%) for three children and 2 (0.3%) for four children.

4.3.1.4 Education: Highest qualification.

The minimum qualification held by all participants was an undergraduate degree. In addition to this, postgraduate qualifications were held by 209 (33%) participants: 189 (30%) had a Master's degree, 17 (2.7%) had a PhD, and 3 (0.5%) had a professional doctorate. Fifty-four (8.6%) participants had other qualifications, the majority of which were

post-graduate diplomas or certificates. Finally, one respondent held a Master of Medicine (MMed) qualification.

4.3.2 Current working profile of participants.

4.3.2.1 Work prior to becoming a speech and language therapist and route into the profession.

In total, 84.5% (*n*=534) of participants had some work experience before becoming an SLT. Table 4.4 presents previous work experience that SLTs held. Numbers do not total 100%, as some participants held more than one job before becoming an SLT.

Table 4.4. Previous work experience

Field of work	**Participant** ***n (% of whole cohort)***
Teaching	70 (11.1)
SLT Assistant	63 (10)
Business	55 (8.7)
Nursing	19 (3.0)
Physiotherapy	3 (0.5)
Occupational therapy	2 (0.3)
Student work	283 (44.8)
Other	247 (39.1)[a]

[a]A wide range of other jobs that had been held were listed e.g., bar work, civil service, researcher, domestic work, hairdresser, care worker, resettlement work, tour guide. These were not included separately as each represented <0.3% of the sample.

4.3.2.2 Route into the profession.

The question regarding route into the profession was answered by 631 participants. Of these, 71.2% (*n*=449) had entered the profession through a traditional undergraduate degree route in the UK. A further 25.2% (*n*=159) had completed a postgraduate (pre-registration) degree, and 3.6% (*n*=23) held a degree obtained abroad that is recognised by the HCPC.

4.3.2.3 Length of time in the profession and in current role.

Qualification dates ranged from 1974 to 2018. Information regarding year of qualification is presented in Table 4.5.

Table 4.5. Year of qualification

Year of qualification	Time in the profession	Participants *n (%)*
2018-2006	1 month -12 years	355 (56.2)
2005-1996	13-22 years	146 (23.1)
1995-1986	23-32 years	97 (15.3)
1985-1974	33-44 years	34 (5.4)

The length of time that participants had been in their current jobs ranged from one month to 39 years, with the majority (n=392, 62%) having spent 5 years or less in their present position. Table 4.6 shows the length of time that participants had been in their current roles.

Table 4.6. Tenure in current job

Length of time in current job	Participants *n* (%)
1 month to 5 years	394 (62.3)
5 years, one month to 10 years	109 (17.3)
10 years, one month to 15 years	72 (11.4)
15 years, one month to 20 years	35 (5.5)
20 years, one month to 25 years	9 (1.4)
25 years, one month to 30 years	8 (1.3)
30 years, one month to 35 years	3 (0.5)
35 years, one month to 39 years	2 (0.3)

4.3.2.4 Geographical location.

Of the sample, 90.5% (*n*=572) participants worked in England, 4.3% (*n*=27) were working in Northern Ireland, 2.8% (*n*=18) were working in Scotland and 2.4% (*n*=15) were working in Wales. Table 4.7 shows how the geographical location of the sample compares to population statistics. Although SLTs working in Scotland were underrepresented, the sample was broadly representative of the population overall.

Table 4.7. Geographic location: Sample and population statistics

Home nation	This sample *n* (%)	UK SLTs[a] *n* (%)
England	572 (90.5)	14, 281 (82.8)
Scotland	18 (2.8)	1, 404 (8.1)
N Ireland	27 (4.3)	821 (4.8)
Wales	15 (2.4)	736 (4.3)
Total	**632 (100%)**	**17, 242 (100%)**

[a]Numbers obtained from the RCSLT member survey, 2018 – received through personal communication with K Maietta (16.11.18)

4.3.2.5 Employment sector.

The majority of participants (84.8%, *n*=536), were organizationally employed. Of those, 93.3% (*n*=500) held one job and 6.7% (*n*=36) held two jobs. Details of the employers of participants with one job are presented in Table 4.8. A further 9.2% (*n*=58) were self-employed. Of those, 49 (84.5%) worked as sole practitioners and nine (15.5%) owned or were the partner in an independent practice where more than one SLT worked. Finally, 6% (n=38) worked as employees for part of the time and were partly self-employed. From now on, this last category will be labelled as 'both'.

Table 4.8. The employers of participants who held one job only (*n*=500)

Employer	Participants *n* (%)
NHS	425 (85)
Third Sector	16 (3.2)
Private Company	15 (3.0)
School (directly)	14 (2.8)
Independent Practice	8 (1.6)
Education Service	6 (1.2)
Higher Education Institution (in a clinical capacity)	4 (0.8)
Other	12 (2.4)

The NHS.

The majority of the participants in this survey were employed in some capacity by the NHS. In addition to those who only held one job in the NHS, a number held portfolio careers, which involved either more than one employer, or a mix of NHS and self-employed work. Of the entire sample, 76% (n=480) were employed in some capacity by the NHS. Table 4.9 presents the numbers of participants in the sample with at least some NHS employment.

Table 4.9. Percentages of participants with at least some employment in the NHS

Employed by the NHS	Participants *n (%)*
NHS only (one job)	425 (67)
NHS & employed by another organisation	30 (5)
NHS & self-employed	25 (4)
Total	**480 (76)**

4.3.2.6 Roles and work setting.

All the participants in this study were working clinically, i.e., at least part of their job required them to hold a caseload – to work with patients/service-users. In total, 90% (*n*=569) were working in a clinical capacity only; 8% (*n*=52) were working in a clinical capacity and had one other role; and 2% (*n*=12) had two additional roles. Other roles included management, research, lecturing, training, and roles as intermediaries. Participants worked across a variety of clinical settings. Data showed that 38.4% (*n*=243) SLTs worked in one setting only. The majority worked across more than one setting, with 21.5% (*n*=136) working in two different settings. The maximum number of settings worked in was 11. In this sample, the largest number of SLTs (45%, *n*=285) worked in the education sector. This included both primary and secondary schools, mainstream and special schools, and both the state and private sectors. Table 4.10 shows the work settings of participants in the cohort.

Table 4.10. Work settings of participants in the cohort

Work setting	**Participants *n (%)***
Community Clinics	257 (40.7)
State Primary Schools (Mainstream)	227 (35.9)
State Hospitals	181 (28.6)
Nurseries	143 (22.6)
Domiciliary (people's homes)	134 (21.2)
Private hospitals, clinics and schools	120 (18.9)
State Secondary Schools (Mainstream)	116 (18.4)
State Primary Special Schools	108 (17.1)
Residential Settings	99 (15.7)
State Secondary Special Schools	71 (11.2)
Other (e.g., HE, ALD day services, youth offending services)	150 (23.7)

Note. The number of participants does not total 100%, as many work in more than one setting, HE = higher education, ALD – Adults with learning difficulties

4.3.2.7 Income and type of contract

Participants were asked to specify a salary band, to indicate their approximate income. The question regarding total earnings was answered by 612 participants. The majority of clinicians (42%, *n*=257) earned between £20,000 and £29,999 per annum. Total reported earnings are shown in Table 4.11.

Table 4.11. Total earnings reported by participants (*n*=612)

Rough annual salary	**Participants *n* (%)**
Less than £20,000 p.a.	63 (10.2)
£20,000 to £29,999 p.a.	257 (42.0)
£30,000 to £39,999 p.a.	183 (29.9)
£40,000 to £49,999 p.a.	80 (13.1)
£50,000 p.a. or above	12 (2.0)
Prefer not to say	17 (2.8)

Main income provider.

In total, 631 participants provided information on the main income provider in their household. Table 4.12 presents this information.

Table 4.12: Main income provider (*n*=631)

Main income provider	**Participants *n* (%)**
Participant (sole provider)	45 (7.1)
Participant (partner also provides an income)	194 (30.7)
Equal provider with partner	201 (31.9)
Partner	191 (30.3)

Full time, part time and flexible working.

Of the 631 participants who reported whether they worked full time, part time or flexible hours, 59% (*n*=372) considered themselves to be working full time (approximately 38 hours per week) and 37.4% (*n*=236) were working part time. In addition, 3.6% (*n*=23) participants reported that they worked flexible hours (i.e., the total number of hours per week changed periodically). Only four of these were organizationally employed, with the remainder being self-employed or being part employed and part self-employed. Of the 621 participants who answered the question about the type of contract they held, 89.2% (*n*=554) held permanent contracts. Fixed term positions were occupied by 7.1% (*n*=44) of participants; 2.9% (n=18) were in temporary positions; 0.6% (*n*=4) had locum jobs and 0.2% (*n*=1) were providing maternity cover.

Paid hours.

Of the 629 participants who provided information about hours they were paid to work, 43.4% (*n*=273) reported that they were paid to work for 37.5 hours per week. The mean number of hours that participants were paid to work was 30.75 (SD=8.79) and the median was 36 hours. The minimum number of hours per week that participants were paid to work was one and the maximum (by a clinician who was self-employed) was 70.

Unpaid hours.

In total, 84.5% (*n*=534) of the 632 participants reported working additional hours, for which they were not paid. The number of extra hours that participants worked on average, per week, ranged from one to 45, with a mean of four and a median of three. Ninety-two

participants (14.6%) worked for more than one extra day (7.5 hours) on average per week, without being paid.

Total number of hours worked.

The total number of hours worked per week by participants was calculated by adding their paid and their unpaid hours. This total ranged from 1.5 hours per week, to 82.5 hours per week. The mean total number of hours worked was 34.8 (SD=9.92), the median was 37.5, and the mode was 39.5. When considering the total number of (paid and unpaid) hours that clinicians worked, 48.1% (*n*=304) worked over 37.5hrs per week, on average. Those who stated that they worked full time (n=372) had a mean total of 40hrs (SD=7.05).

4.3.2.8 Absenteeism and Presenteeism.

The data showed that 39% (*n*=247) SLTs had taken sick leave within the last nine months and 16% (*n*=102) had taken a mental health self-care day. Of those who had taken a mental health self-care day, 43% (*n*=44) stated that they had been honest about doing so. Eighty-two percent of participants (*n*=518) said that they saw taking sick leave as a last resort and 85% (*n*=538) reported going to work when feeling unwell.

4.3.3 Job characteristics.

4.3.3.1 Usual caseload size.

Of the sample, 594 participants answered a question asking what their 'usual' caseload size was. The mean usual caseload size was 57 (SD = 59.16, with a minimum of 1 and a maximum of 500). Table 4.13 shows the usual caseload size across the sample,

Table 4.13: Usual caseload size (*n*=594)

Usual caseload size	Participants n=594
1-10	63 (10.6)
11-20	94 (15.8)
21-30	49 (8.2)
31-40	113 (19.0)
41-50	56 (9.4)
51-60	38 (6.4)
61-80	58 (9.8)
81-100	48 (8.1)
>100	75 (12.6)

Caseload sizes in different work settings.

Because many SLTs work in multiple settings, it is difficult to establish whether caseloads of differing sizes are associated with particular settings. The work setting listed in Table 4.14 therefore shows that a participant's work incorporates (but is not necessarily limited to) a particular setting. Within all settings, there was a sizeable spread within the data, but consideration of all three measures of central tendency revealed that those clinicians whose work included being in state schools tended to have larger caseloads than those who did not. Data does not take into account whether participants worked full-time or part-time. For those participants who reported that they worked in one setting only (Table 4.15), most worked in a state hospital.

Table 4.14. Caseload sizes in different settings

Work setting includes	Mean (*SD*)	Mode	Median
Secondary Special school	87 (68)	100	73
Primary Special schools	81 (61)	50	67
Mainstream primary schools	74 (57)	60	60
Mainstream secondary schools	74 (59)	50	52
Nursery schools	72 (57)	60	55
Community Clinics	71 (61)	50	50
Residential settings	51 (72)	40	31
State hospitals	48 (70)	30	30
Domiciliary work	45 (56)	30	30
Private clinics	39 (33)	15	28
Private hospitals	39 (45)	15	16
Private primary schools	49 (48)	15	30
Private Secondary schools	49 (48)	12	26

Table 4.15. Caseload sizes for participants working in only one setting

Work setting	Mean (*SD*)
Primary Special schools (*n*=3)	77.33 (4.62)
Mainstream primary schools (*n*=7)	75.86 (36.44)
Nursery schools (*n*=1)	70.0 (0)
Community Clinics (*n*=13)	70.54 (96.30)
Residential settings (n=2)	44.0 (5.66)
State hospitals (*n*=72)	35.35 (54.47)
Private clinics (*n*=2)	105.0 (63.64)

Note. No participants reported that they worked only in secondary schools (mainstream or special), only in domiciliary settings, or only in private hospitals or schools.

Tasks at work.

Part of caseload management includes face-to-face work with client/patients. Of the 602 participants who answered the question regarding the percentage time spent on different work tasks, 95 included tasks that totalled more than 100% of their time. After the removal of these cases 507 participants remained. On average, working face-to-face with clients comprised 38% of an SLT's time spent at work, with the lowest time spent in face-to-face sessions being 2% and the highest being 90%. Other activities that accounted for participants' time varied considerably and included administration, email, travel, meetings, liaison, 'therapy related activities', and training.

4.3.3.2 Number of sites visited weekly by SLTs.

Of the sample, 30% (*n*=189) worked at one site only, 17% (*n*=107) visited two sites on a weekly basis. Most (53%, *n*=334) worked across three or more sites over a typical week. The median number of sites worked in during a week in was three.

4.3.3.3 A designated space in which to work.

The amount of time that participants had a designated space to work is shown in Table 4.16.

Table 4.16. Having a designated space in which to work

A designated space to work	Participants *n* (%)
All the time	359 (56.8)
Some of the time	240 (38.0)
Never	33 (5.2)

Of the 43% (*n*=273) of SLTs who were required to work in makeshift spaces, 52% (*n*=141) had to find alternatives for two or more days in a week, 32% (*n*=87) had to do this once a week and the remainder (16%, *n*=45) found alternatives for less than a day a week. The mean number of days that people were required to find alternative spaces to work was 2.14, with the minimum being one third of a day and the maximum being every day of the working week. Table 4.17 shows the alternative spaces that participants worked in.

Table 4.17. Alternative spaces in which to work

Alternative spaces in which to work	Participants *n* (%)
The corner of somebody else's office	189 (29.9)
Their car (for completing administrative tasks)	75 (11.9)
A corridor	74 (11.7)
Other[a]	168 (26.6)

Note. The total does not equal the number who stated they were required to work in makeshift spaces, as some participants selected more than one option

[a]Those who had found other spaces in which to work listed a variety of areas, including in 'busy' classrooms, school libraries, 'crowded' offices, at home, in staff rooms, on the ward, on the bus (dealing with emails), in other staff members' offices, foyers in nursing homes, the hospital canteen or hospital library, the IT room, the kitchen, coffee shops, meeting rooms, and music practice rooms.

4.3.3.4 Use of Information and Communications Technology.

Use of information and communications technology by SLTs is shown in Table 4.18.

Table 4.18. Number of minutes spent on different ICT devices

Device	Number of participants who used the device (%[a])	Mean length device was used on a daily basis (*SD*)
Telephone	589 (93)	32min (26.29)
Desktop	407 (64)	85min (97.31)
Laptop	272 (43)	53min (87.83)
Tablet	163 (26)	11min (27.92)

[a]Percentages do not total 100, as some participants used more than one device on a daily basis.

Email usage.

In total, 93.2% (*n*=589) of participants stated that they responded to email throughout the day and 41% (*n*=259) reported that they read and sent emails outside of working hours. Participants accessed their emails on their desktops, laptops, phones, and tablets. Table 4.19 provides details of the use of these devices.

Table 4.19. Devices used to access emails

Device	Participants using the device to access emails (%[a])
Desktop	492 (77.8)
Laptop	346 (54.7)
Phone	246 (38.9)
Tablet	112 (17.7)

[a]Percentages do not total 100, as some participants accessed their emails on more than one device.

4.3.3.5 Physical demands.

In total, 79.6% (*n*=503) of participants stated that their work involved regular or routine manual handling (e.g., assisting clients to move or carrying heavy items such as patient files or bags of therapy equipment). Of those 503 participants, 40% (*n*=201) used manual handling skills every day. The median number of days that people used these skills was four. Of the 503 participants whose work regularly involved manual handling, 92% (*n*=465) had received manual handling training. One hundred and seven participants had received manual handling training, although their work did not involve manual handling.

In addition to manual handling, participants were asked whether their jobs involved any other physical demands. Table 4.20 provides an itemisation of the demands listed by participants.

Table 4.20. Additional physical demands

Physical demand	**Participants *n* (%)**
Prolonged work on a computer/tablet/keyboard	419 (66.3)
Prolonged sitting	294 (46.5)
Sitting in very small chairs	243 (38.4)
Bending	238 (37.7)
Sitting in awkward postures	230 (36.4)
Crouching	228 (36.1)
Long periods of driving	212 (33.5)
Using uncomfortable/inappropriate furniture	170 (26.9)
Prolonged use of the telephone	81 (12.8)
Other[a]	113 (17.9)

Note. Percentages do not total 100, as some participants access their emails on more than one device.

[a]Examples of other physical demands provided by participants included long periods of standing, kneeling, crawling, sitting or playing on the floor, manoeuvring trolleys, physical activities on the playground with children, physical interventions such as using restraint (e.g., with service-users with challenging behaviour), pushing wheelchairs, and standing in awkward positions e.g., over hospital beds to provide oral care.

Workstations.

Of the sample, 76% (n=480) of participants reported that the seating at the desk/table where they did paperwork was suitable. Of these, 34% (n=164) had undertaken a display screen equipment (DSE) assessment for their current workstation. Three percent (n=17) reported that despite having had a DSE assessment for their current workstation, the desk

where they did paperwork was not suitable. The remaining 21% (n=135) felt that their desk was not suitable and reported that they had not had a DSE assessment.

4.3.4 Dispositional traits: The four core self-evaluations.

The four core self-evaluations (Judge et al., 1998), with negative affect used as a proxy for neuroticism (Judge et al., 1998), were assessed. In addition to the four core self-evaluations; optimism was measured. Table 4.21 provides descriptive statistics for individual differences.

Table 4.21. The four core self-evaluations & optimism

Self-evaluation of dispositional trait	Mean (*SD*)[a]
Self-esteem (*n*=630)	7.03 (2.04)
Generalised self-efficacy (*n*=631)	7.61 (1.69)
Locus of control (*n*=631)	7.21 (1.62)
Negative affect (*n*=631)	3.66 (2.09)
Optimism (*n*=631)	6.96 (2.03)

[a]Minimum score =1, maximum score= 10

4.3.5 The psychosocial work experience: environment and outcomes.

The following sections provide a summary of the results from two single items and the standardised scales that formed part of the questionnaire and evaluated the psychosocial work experience, both in terms of the environment and well-being outcomes. Occupational stressors, stress outcomes, happiness, whether a job was worthwhile, job satisfaction, and general biopsychosocial well-being were measured.

4.3.5.1 Occupational Stress: The Speech Language Pathologist Stress Inventory (SLPSI).

The possible range of scores on the SLPSI is from 1 (*no stress*) to 5 (*extremely severe stress*). The mean 'Total Stress Score' for the current sample on the SLPSI was 2.7 (SD=.50), which corresponds to 'moderate' levels of stress (Fimian, et al., 1991). The percentages of participants in each SLPSI band are presented in Table 4.22.

Table 4.22. Mean SLPSI scores

SLPSI Score	Level of stress	Participants *n* (%)
1.00-1.99	None-Mild	50 (8)
2.00-2.99	Mild-Moderate	386 (61)
3.00-3.99	Moderate-severe	195 (30.8)
4.00-4.99	Severe-Extremely severe	1 (0.2)
5.00	Extremely severe	0 (0)

Four of the SLPSI subscales were reliable, with the Instructional Limitations and Biobehavioural Manifestations almost reaching reliability. When the whole scale is considered, the SLPSI performed better with regards to reliability. The Cronbach's Alpha scores, mean scores and standard deviations for each SLPSI subscale are presented in Table 4.23.

Table 4.23. SLPSI subscale Cronbach's Alpha and mean scores

SLPSI Subscale	Cronbach's Alpha	Mean (*SD*)	Sample min mean score for subscale	Sample max mean score for subscale
Time & Workload Management	0.894	3.50 (.77)	1	5
Bureaucratic Restrictions	0.847	2.79 (.83)	1	5
Instructional Limitations	0.692	2.69 (.55)	1	4.43
Lack of Professional Support	0.792	2.62 (.61)	1.09	4.45
Bio-behavioural Manifestations[a]	0.680	1.94 (.64)	1	4.17
Emotional-fatigue Manifestations[a]	0.816	2.55 (.58)	1	4.40
SLPSI Total	0.933	2.71 (.50)	1.13	4.04

[a]The mean score for all sixteen SLPSI *Outcomes of Stress* items (i.e., items from both the Bio-behavioural Manifestations and the Emotional-Fatigue Manifestations subscales) was 2.32 (SD = 0.54).

Based on Likert scoring, the highest mean score in relation to sources of occupational stress was time and workload management (M = 3.5, SD = 0.8). Tables 4.24 – 4.29 present a breakdown of the mean scores for each item of the six SLPSI subscales.

SLPSI Sources of stress scales: the psychosocial work environment

1. *SLPSI-Time and workload management.*

Table 4.24 presents mean scores for the sub-items of *Time and Workload Management*. All mean scores on this subscale fell between 3 ('moderate stress') and 4 ('severe stress').

Table 4.24. Mean scores on the SLPSI Time and Workload Management subscale

SLPSI – Time and Workload Management	**Mean (*SD*)**	**Min**	**Max**
Too much work to do	3.95 (.950)	1	5
Too much paperwork	3.76 (1.03)	1	5
Easily overcommitted	3.56 (.980)	1	5
Little time for personal work targets	3.55 (1.02)	1	5
Caseload is too big	3.35 (1.21)	1	5
No time to get tasks done	3.32 (.970)	1	5
Little time to prepare adequately for sessions	3.30 (.970)	1	5
Not time to relax	3.28 (1.00)	1	5

2. SLPSI Bureaucratic restrictions.

The mean scores for the sub-items related to *Bureaucratic Restrictions* is presented in Table 4.25

Table 4.25. Mean scores on the SLPSI Bureaucratic Restrictions subscale

SLPSI – Bureaucratic Restrictions	**Mean (*SD*)**	**Min**	**Max**
Administrative policies limit effectiveness	3.41 (1.12)	1	5
Administrative policies limit professional growth	3.06 (1.17)	1	5
Lacks control over service delivery models	3.03 (1.16)	1	5
Lacks continuing professional development opportunities	2.66 (1.14)	1	5
Professional needs are unmet at work	2.65 (1.09)	1	5
Lacks emotional and intellectual stimulation	1.91 (.93)	1	5

3. SLPSI-Instructional Limitations.

Table 4.26 presents mean scores for the sub-items related to *Instructional Limitations*.

Table 4.26. Mean scores on the SLPSI Instructional Limitations subscale

SLPSI – Instructional Limitations	**Mean (*SD*)**	**Min**	**Max**
Required to manage behaviour problems	3.21 (.97)	1	5
Works with too many patients/clients with different and/or complex needs	2.95 (1.23)	1	5
Patients/carers are poorly motivated	2.84 (.78)	1	5
Patients/clients make little progress	2.65 (.72)	1	5
Experiences inflexible scheduling	2.61 (1.02)	1	5
Patients/clients are not improving	2.44 (.77)	1	5
Lacks adequate training for job requirements	2.12 (.89)	1	5

4. SLPSI-Professional Support.

The mean scores for the sub-items related to *Professional support* are presented in Table 4.27.

Table 4.27. Mean scores on the SLPSI Lack of Professional Support subscale

SLPSI – Lack of Professional Support	Mean (*SD*)	Min	Max
Feels other professionals do not understand the work of an SLT	3.23 (1.02)	1	5
Lacks opportunity for promotion/advancement	3.20 (1.29)	1	5
Receives an inadequate salary	3.08 (1.31)	1	5
Feels the public doesn't value the work that an SLT does	3.05 (1.00)	1	5
Lacks sufficient resources	2.93 (1.12)	1	5
Lacks recognition from other professionals	2.57 (.86)	1	5
Lacks adequate space in which to work	2.44 (1.14)	1	5
Lacks support	2.36 (1.03)	1	5
Lacks opportunities to consult with other SLTs	2.14 (1.09)	1	5
Experiences poor professional interactions	2.06 (.83)	1	5
Doesn't feel like a member of the team in the setting where works	1.81 (1.02)	1	5

SLPSI Outcomes of stress scales.

5. SLPSI-Bio-behavioural Manifestations.

Table 4.28 present the mean scores for *Bio-behavioural Manifestations*.

Table 4.28. Mean scores on the SLPSI Bio-behavioural Manifestations subscale

SLPSI – Bio-behavioural Manifestations	**Mean (*SD*)**	**Min**	**Max**
Gets angry	2.18 (.87)	1	5
Uses prescription/over-the-counter drugs	2.05 (1.37)	1	5
Uses alcohol to wind down	1.98 (1.00)	1	5
Experiences heart racing or pounding	1.90 (1.01)	1	5
Experiences stomach pain	1.87 (1.00)	1	5
Experiences rapid and shallow breathing	1.65 (.90)	1	5

6. SLPSI-Emotional-fatigue Manifestations.

The mean scores for *Emotional-fatigue Manifestations* are presented in Table 4.29.

Table 4.29. Mean scores on the SLPSI Emotional-fatigue Manifestations subscale

SLPSI – Emotional-fatigue Manifestations	**Mean (*SD*)**	**Min**	**Max**
Feels fatigued	3.49 (.92)	1	5
Feels anxious about work	2.86 (1.02)	1	5
Procrastinates	2.77 (.92)	1	5
Thinks about other things while at work	2.75 (.85)	1	5
Feels professional life is not contributing to personal life	2.74 (1.05)	1	5
Feels insecure	2.62 (.96)	1	5
Feels unable to cope	2.42 (.93)	1	5
Sleeps more than usual	2.30 (1.04)	1	5
Feels depressed	2.11 (.93)	1	5
Calls in sick when not physically unwell	1.44 (.80)	1	5

The largest contributor to stress was having too much work to do (M=3.95, SD = 1.0), with 67% (*n*=385) of respondents stating that they often or always had too much work to do. The top 10 stressors included all eight items from the time and workload management subscale. The greatest manifestation of stress for the sample, across both the bio-behavioural and emotional-fatigue subscales was fatigue (M=3.49, SD = 0.9).

4.3.5.2 Classification of jobs using the Job Demand Control Support Model.

The JDCS model (Karasek, 1979; Johnson & Hall, 1988) was used to categorise the participants into job types. A full description of how this classification was achieved was provided in the methods chapter. In brief, the SLPSI subscale *Time and Workload Management* (TWM) represented demand; control was represented by the combined SLPSI *Bureaucratic Restrictions* (BR) and *Instructional Limitations* (IL) subscales (i.e., the new *Professional Autonomy* (PA) subscale), and *Lack of Professional Support* (LPS) represented support.

Of the 632 participants included in the analysis, 40% (n=253) held active jobs. A further 33% (n=206) held high-strain jobs, 25% (n=160) had low strain jobs and 2% (n=13) had passive jobs. The JDCS classification of the sample is shown in Table 4.30.

Table 4.30. JDCS classification of the sample

Job type	**Participants** *n* **(%)**
Active Collective	222 (35)
Active Isolated	31 (5)
Passive Collective	8 (1.2)
Passive Isolated	5 (0.8)
High-strain Collective	101 (16)
High-strain Isolated (IsoStrain)	105 (17)
Low-strain Collective	153 (24)
Low-strain Isolated	7 (1)

4.3.5.3 Happiness at work and feeling that the job is worthwhile.

When asked how happy they were in their jobs, 72% (n=454) of SLTs in this study rated their happiness at seven or above out of 10 (M=7.26, SD=2.07). Asked whether their job was worthwhile, 97% (n=613) agreed that it was.

4.3.5.4 Job satisfaction: The General Job Satisfaction Scale (GJSS).

The GJSS achieved good reliability (α=0.838) with the current sample of participants. The minimum possible score on the GJSS was 10, and the maximum was 50. The mean job satisfaction score for the sample was 36.31 (SD = 6.54), which was within the 'average' band of 32-38 (Macdonald & McIntyre, 1997). Table 4.31 shows the mean scores on the GJSS.

Table 4.31. Mean GJSS scores

Band	**Descriptor**	**Participants *n (%)***
10-26	Very low	50 (8)
27-31	Low	88 (14)
32-38	Average	240 (38)
39-41	High	120 (19)
42-50	Very high	133 (21)

The highest and lowest mean scores were associated with work relationships. Eighty-five percent (*n*=540) of participants agreed or strongly agreed that they had good relationships with their supervisors. In contrast, only 40% (*n*=253) felt that management was concerned about them. Table 4.32 shows the items of job satisfaction to receive the highest and lowest mean scores, for the whole sample.

Table 4.32. Highest and lowest mean scores on individual GJSS items

Variable *n*=631	**Mean (*SD*)**
I get along with my supervisors	4.26 (0.76)
I believe management is concerned about me	3.06 (1.24)

4.3.5.5 Biopsychosocial well-being: The General Health Questionnaire-28 (GHQ-28)

Table 4.33 displays the descriptive statistics for the subscales and total Likert and Binary scores for the sample completing the GHQ-28. All subscales were found to be reliable, as shown by the Cronbach's Alpha Scores in Table 4.33. Fifteen participants did not complete the GHQ-28 and were excluded from the analysis.

Table 4.33. GHQ-28 subscales and total Likert and Binary scores (*n*=617)

GHQ-28 Sub-scales	**Cronbach's Alpha**	**Mean (*SD*)**	**Sample min**	**Sample max**
Somatic Symptoms	0.857	7.08 (4.4)	0	21
Anxiety	0.903	7.13 (5.0)	0	21
Social Dysfunction	0.813	8.08 (2.6)	1	20
Depression	0.881	1.58 (2.9)	0	18
GHQ-28 Likert Total	**0.932**	**23.85 (12.1)**	**4**	**67**
GHQ-28 Binary Total	**0.915**	**5.90 (6.0)**	**0**	**26**

The alternative binary method of scoring the GHQ-28 (with the two least symptomatic answers scoring 0 and the two most symptomatic answers scoring 1) classifies any score meeting the threshold value of 4 as achieving 'caseness' (Jackson, 2007). This 'caseness' is an indication of psychological distress. Of the 617 participants who completed the GHQ-28, 53.3% (*n*=329) had binary scores of 4 or more, indicating that they had achieved 'caseness', and showing that an assessment by their general practitioner would likely result in further intervention or investigation (Jackson, 2007).

The binary scores can be further classified into three bands (Nolan & Ryan, 2008): no stress, mild stress (likely to resolve with intervention), and severe stress (unlikely to resolve without intervention). Table 4.34 presents the distribution of scores for each of the above stress bands.

Table 4.34. GHQ-28 banded stress scores (*n*=617)

Stress Band	***n* (%)**
No distress (scores ≤ 3)	288 (46.7)
Mild distress (scores 4-6)	91 (14.7)
Severe distress (scores ≥ 7)	238 (38.6)

Tables 4.35 to 4.38 present a breakdown of the mean scores for each item of the four GHQ-28 sub-scales.

GHQ-28 Somatic Symptoms

Table 4.35 presents mean scores for the sub-items for GHQ-28 Somatic Symptoms.

Table 4.35. Mean scores on the GHQ-28 Somatic Symptoms subscale

GHQ – Somatic symptoms	**Mean (*SD*)**	**Min**	**Max**
Been feeling run down and out of sorts?	1.36 (.879)	0	3
Been feeling perfectly well and in good health? (higher score denotes worse health)	1.35 (.638)	0	3
Been feeling in need of a good tonic?	1.20 (.882)	0	3
Felt that you are ill?	0.96 (.913)	0	3
Been getting any pains in your head?	0.86 (.919)	0	3
Been getting a feeling of tightness or pressure in your head?	0.79 (.961)	0	3
Been having hot or cold spells?	0.56 (.796)	0	3

GHQ-28 Social Dysfunction

Mean scores for the sub-items for GHQ-28 Social Dysfunction are presented in Table 4.36.

Table 4.36. Mean scores on the GHQ-28 Social Dysfunction subscale

GHQ – Social Dysfunction	**Mean (*SD*)**	**Min**	**Max**
Been taking longer over the things you do?	1.26 (.535)	0	3
Felt on the whole you were doing things well?	1.21 (.528)	0	3
Been satisfied with the way you've carried out your task?	1.21 (.539)	0	3
Been able to enjoy your normal day-to-day activities?	1.20 (.547)	0	3
Felt capable of making decisions about things?	1.15 (.543)	0	3
Felt that you are playing a useful part in things?	1.12 (.558)	0	3
Been managing to keep yourself busy and occupied?	0.93 (.470)	0	3

GHQ-28 Anxiety and Insomnia

Table 4.37 presents mean scores for the sub-items for GHQ-28 Anxiety and Insomnia.

Table 4.37. Mean scores on the GHQ-28 Anxiety and Insomnia subscale

GHQ – Anxiety and Insomnia	**Mean (*SD*)**	**Min**	**Max**
Felt constantly under strain	1.20 (.918)	0	3
Found everything getting on top of you	1.15 (.896)	0	3
Been getting edgy and bad-tempered	1.10 (.862)	0	3
Lost much sleep over worry	1.06 (.910)	0	3
Had difficulty in staying asleep once you are off	0.99 (.950)	0	3
Been feeling nervous and strung-up all the time	0.92 (.890)	0	3
Been getting scared or panicky for no good reason	0.72 (.853)	0	3

GHQ-28 Depression

Mean scores for the sub-items for GHQ-28 Depression are presented in Table 4.38.

Table 4.38. Mean scores on the GHQ-28 Depression subscale

GHQ – Depression	Mean (*SD*)	Min	Max
Been thinking of yourself as a worthless person	0.50 (.743)	0	3
Found at times you couldn't do anything because your nerves were too bad	0.31 (.620)	0	3
Felt that life is entirely hopeless	0.24 (.569)	0	3
Felt that life isn't worth living	0.14 (.428)	0	3
Thought of the possibility that you might make away with yourself	0.14 (.457)	0	3
Found that the idea of taking your own life kept coming into your mind	0.14 (.489)	0	3
Found yourself wishing you were dead and away from it all	0.11 (.409)	0	3

The three items that had the highest scores, and which were therefore of particular concern were 'feeling run down and out of sorts' (M=1.36, SD = 0.9), not 'feeling well and in good health' (M=1.35, SD=0.6) and 'taking longer over things you do' (M=1.26, SD=0.5).

4.4 Summary of Descriptive Results

SUMMARY

1. Due to the method of participant recruitment, it is not possible to report a response rate. The 632 SLTs in this sample represent around 4% of the 15, 932 SLTs that were registered with the HCPC in 2017, the latest figures available when the survey took place in 2018.
2. Of the SLTs in this sample, 98% were women, which is consistent with the population demographics of UK SLTs. Ninety-five percent were white.
3. The average age of participants was 38.7 years.
4. Most participants were married (54%) and most were not caring for children at home (64%).
5. SLTs in this sample were generally optimistic, had good self-esteem, high levels of self-efficacy, an internal locus of control, and low negative affect.
6. The majority had some work experience prior to becoming an SLT, and had entered the profession through the traditional undergraduate route in the UK.

7. Most participants were working in England and were organizationally employed, with the largest employer being the NHS.
8. Three fifths worked full-time, with most earning between £20,000 and £29,000.
9. The bulk of participants (85%) worked extra unpaid hours in addition to their contracted hours.
10. The highest percentage of participants (45%) worked in the education sector.
11. The mean caseload size was 56, with those working in state schools carrying the largest caseloads. On average, 38% of an SLT's time was spent delivering face-to-face intervention.
12. A sizeable group (43%) of SLTs did not always have a designated space in which to work, and just over half worked in three or more sites over a week.
13. Most participants reported having physically demanding jobs, with 80% being required to engage in manual handling and/or carrying/moving heavy equipment.
14. Most (93%) responded to emails throughout the day, and 40% read and sent emails outside of working hours.
15. More than double the number of SLTs (*n*=538, 82%) had gone to work when feeling ill in the previous nine months, as had taken sick leave (*n*=247, 39%).
16. Three fifths of SLTs had moderate to severe levels of occupational stress.
17. The principle environmental stressor was demand as a result of heavy workloads combined with a lack of time.
18. Administrative policies which limited effectiveness were seen as the biggest contributor to a lack of control.
19. Feeling that other professionals did not understand the work of an SLT was ranked highest in terms of feeling unsupported.
20. The highest-ranking manifestation of stress for participants was feeling fatigued, followed by feeling anxious at work and procrastinating.
21. Two fifths of participants had active jobs, a third had high strain jobs and a quarter had low strain jobs.
22. High or very high levels of job satisfaction was reported by two fifths of SLTs.
23. Just over half of all participants (53%) achieved 'caseness' on the GHQ-28, indicating that they would receive further attention if visiting a GP.
24. Participants scored worst on the GHQ-28 subscale measuring their ability to function well on a social level.
25. The three items where SLTs scored highest on the GHQ-28 were feeling run down and 'out of sorts', not feeling well and in good health and taking longer than normal to do things

The following chapter will build upon the findings discussed thus far, by presenting the inferential and qualitative results from the first phase of the research.

CHAPTER FIVE: THE NOMOTHETIC PHASE INFERENTIAL AND QUALITATIVE RESULTS

5.1 Overview of this chapter

This chapter presents the inferential and qualitative analysis of data from Phase One. It begins by comparing the level of occupational stress reported by the current participants to a norm established by Fimian et al. in 1991. Job satisfaction and general biopsychosocial well-being across four JDCS job types are compared, followed by an exploration of the relationship between elements of the occupational psychosocial environment and well-being outcomes and an analysis of how those elements predict well-being. Both additive and interactive effects of the psychosocial work environment are considered. The way that dispositional traits mediate the relationship between the occupational psychosocial environment and well-being, and how well-being differs across different employment sectors is reported. Then, the well-being of participants is compared across two time points. The remainder of the chapter details the qualitative analysis of the open-ended question at T1.

Unless otherwise stated, statistically significant results are presented in bold font.

5.2 Occupational stress: comparing this sample to the previous normative data

For normative comparison, the mean SLPSI score for this study was compared to the mean SLPSI score reported in Fimian et al’s original 1991 study. The mean total stress score for the current sample was 2.7, which is interpreted as ‘mild to moderate’ stress. There was no statistically significant difference in the overall stress scores between the two groups. The current participants reported statistically significantly higher scores on the *Bureaucratic Restrictions*, the *Instructional Limitations*, the *Biobehavioural Manifestations* and the *Emotional-fatigue Manifestations* subscales, and statistically significantly lower scores on the *Lack of Professional Supports* subscale. There was no statistically significant difference for the *Time and Workload Management* subscale, which received the highest mean score for both groups. Table 5.1 describes the results of the single sample t-test used to make the comparison.

Table 5.1. Comparison of the occupational stress scores for this study and those of the original cohort (Fimian, et al.,1991)

Total & subscales	**This study (*n*=632)**		**Fimian (*n*=626)**			
	M	SD	M	SD	t	p
Total stress score	2.7	0.5	2.7	0.6	0.87	.384
TWM	3.5	0.8	3.6	0.8	-1.93	.053
BR	2.8	0.8	2.7	0.9	2.90	**.004**
IL	2.7	0.6	2.6	0.7	3.86	**<.001**
LPS	2.6	0.6	2.9	0.8	-9.78	**<.001**
BBM	1.9	0.6	1.6	0.6	12.61	**<.001**
EFM	2.6	0.6	2.5	0.8	3.00	**.003**

Note. TWM=Time & Workload Management, BR = Bureaucratic Restrictions, IL = Instructional Limitations, LPS = Lack of Professional Support, BBM = Biobehavioural Manifestations, EFM = Emotional-fatigue Manifestations

5.3 Comparing well-being across JDCS job types

Two measures of well-being were assessed: job satisfaction (using the GJSS) and general biopsychosocial well-being (using the GHQ-28). The low-strain collective group scored highest on job satisfaction (M = 40, SD = 5.3) and lowest on the GHQ-28 (M = 16, SD = 7.7) indicating that participants in this group had relatively better general biopsychosocial well-being than in other groups. The IsoStrain group scored lowest on job satisfaction (M = 29, SD = 5.9), and highest on the GHQ-28 (M = 32, SD = 13.7) indicating relatively worse general biopsychosocial well-being for participants in this group than in other groups. According to the GJSS, both the IsoStrain and Passive isolated groups had low satisfaction. Participants at risk for psychiatric disorder (i.e., GHQ-28 total score >22) were those in the High-strain collective and IsoStrain groups, the Active Collective and Active Isolated groups, and the Passive Collective and Passive Isolated groups. Only the two Low-strain groups were not at risk. Scores for all the groups are presented in Table 5.2.

Table 5.2. GJSS & GHQ-28 mean scores for the JDCS model groups

Job Type	**GJSS M (*SD*)**	**GJSS satisfaction score**	**GHQ-28 M (*SD*)**	**Risk of psychiatric disorder?**
Active Collective (*n*=222)	38.5 (4.7)	High	22.9 (10.7)	Borderline
Low-strain Collective (*n*=153)	40.2 (5.3)	High	16.7 (7.7)	No
High-strain Collective (*n*=101)	33.6 (5.2)	Average	27.9 (11.6)	Yes
Passive Collective (*n*=8)	32.5 (6.6)	High	22.8 (10.7)	Borderline
Active Isolated (*n*=30)	33.2 (5.3)	Average	30.2 (11.3)	Yes
Passive Isolated (*n*=5)	29.6 (1.9)	Low	23.2 (10.4)	Yes
Low-strain Isolated (*n*=7)	34.9 (3.4)	Average	21.4 (10.5)	No
IsoStrain (*n*=105)	29.1 (5.9)	Low	32.5 (13.7)	Yes

A one-way MANOVA was conducted to determine the effect that job type had on well-being (according to the JDCS model). Of the 8 possible job classifications that the JDCS model includes, four groups represented only 8% of the sample. Due to very small numbers in these four groups, they were not included in further analysis, which compared participants in the following groups: Active Collective (Group 1), Low-strain Collective (Group 2), High-Strain collective (Group 3) and IsoStrain (Group 4). Assumption testing was carried out, and details of this, with resulting decisions regarding data treatment and tests carried out, can be found in Appendix C16i.

The GJSS scores and GHQ-28 scores for the four remaining groups are reported in Figures 5.1 and 5.2.

Figure 5.1. The GJSS scores for the four job types retained for analysis

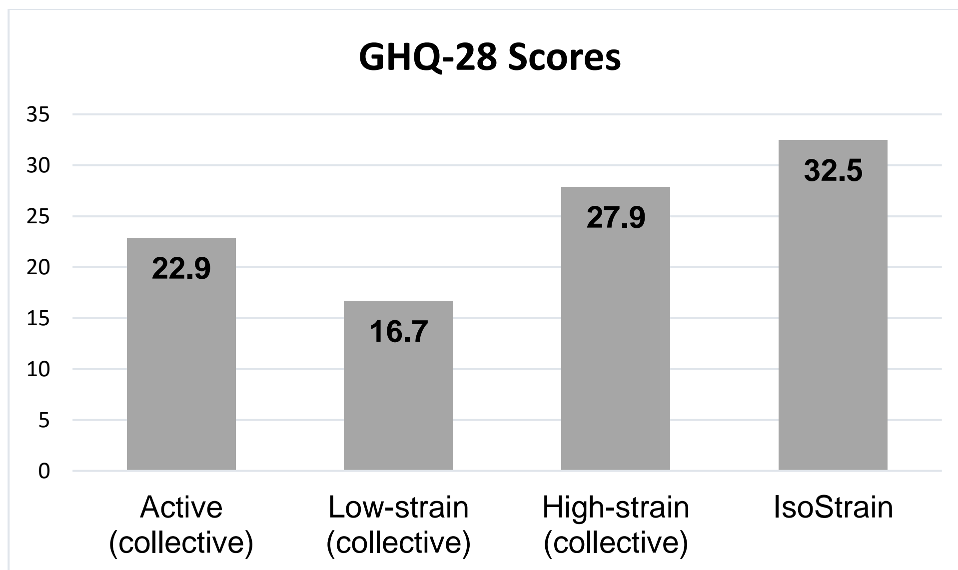

Figure 5.2. The GHQ-28 scores of the four job types retained for analysis

The differences between the four groups on the combined dependent variables was statistically significant, $F(6,1126) = 52.016$, $p < .001$; Pillai's Trace = .434; partial $\eta^2 = 0.217$. Follow-up univariate ANOVAs showed that both job satisfaction scores ($F(3,563) = 116.507$, $p < .001$, partial $\eta^2 = 0.383$) and general biopsychosocial well-being scores ($F(3,563) = 49.932$, $p < .001$, partial $\eta^2 = 0.210$) were statistically significantly different between the SLTs in the different groups. Partial eta-squared values indicate a large effect size for all differences. Games-Howell post-hoc tests showed that the difference in job satisfaction scores was statistically significant between all groups. Scores are shown in Table 5.3.

Table 5.3. Difference in GJSS scores for the four retained job types

JDCS Group (a)	JDCS Group (b)	Mean difference between (a) and (b)	*p*	95% Confidence Interval (CI)	
				Lower CI	Higher CI
Active collective	Low-strain collective	-1.69	**.013**	-3.13	-0.26
	High-strain collective	4.94	**<.001**	3.47	6.42
	Isostrain	9.43	**<.001**	7.67	11.18
Low-strain collective	High-strain collective	6.63	**<.001**	4.95	8.32
	Isostrain	11.12	**<.001**	9.19	13.05
High-strain collective	Isostrain	4.49	**<.001**	2.52	6.45

For general biopsychosocial well-being, Games-Howell post-hoc tests showed that scores were statistically significantly different between all groups apart from the High-Strain Collective and IsoStrain groups, which narrowly failed to reach significance ($p = .059$). Scores are shown in Table 5.4.

Table 5.4. Difference in GHQ-28 scores for the four retained job types

JDCS Group (a)	**JDCS Group (b)**	**Mean difference between (a) and (b)**	***p***	**95% Confidence Interval (CI)**	
				Lower CI	Higher CI
Active collective	Low-strain collective	6.20	**<.001**	3.74	8.65
	High-strain collective	-4.91	**.003**	-8.54	-1.29
	Isostrain	-9.55	**<.001**	-13.56	-5.53
Low-strain collective	High-strain collective	-11.11	**<.001**	-14.69	-7.53
	Isostrain	-15.75	**<.001**	-19.72	-11.79
High-strain collective	Isostrain	-4.64	.059	-9.40	0.12

5.4 The relationship between the psychosocial work environment and well-being

All four SLPSI contributor subscales (stressors) were significantly correlated with the manifestation subscales (stress outcomes). Furthermore, the strength of correlation between all four contributors and the *Emotional-fatigue Manifestation* subscale was moderate (i.e., r >.4, Dancey & Reidy, 2017). In addition, the four SLPSI contributor subscales were significantly negatively correlated with job satisfaction; with the *Bureaucratic Restrictions* and *Lack of Professional Support* subscales having moderate negative correlations with job satisfaction. Finally, all four contributor subscales were also correlated with general biopsychosocial well-being, indicating deteriorating general biopsychosocial well-being when stressors worsen. *Time and Workload Management* and a Lack of *Professional Support* were moderately correlated with GHQ-28 scores. Table 5.5 displays the correlations between the predictor variables and outcome variables. Moderate correlations between predictor variables and outcome variables are highlighted in bold font.

Table 5.5. Overall correlations between job demands, control, support and well-being outcomes

	1.	2.	3.	4.	5.	6.	7.
1. SLPSI Time & Workload							
2. SLPSI Instructional Limitations	.529**						
3. SLPSI Bureaucratic Restrictions	.605**	.594**					
4. SLPSI Lack of Professional Support	.524**	.559**	.680**				
5. SLPSI Biobehavioural Manifestations	.315**	.258**	.304**	.319**			
6. SLPSI Emotional/fatigue Manifestations	**.510****	**.440****	**.452****	**.511****	.613**		
7. GJSS Total	-.389**	-.395**	**-.628****	**-.669****	-.246**	-.490**	
8. GHQ Total	**.415****	.304**	.389**	**.421****	.567**	.659**	-.453**

Note. *n*= 632 for SLPSI & GJSS, *n*=617 for GHQ

***p*<.01

5.5 Occupational psychosocial predictors of job satisfaction and general biopsychosocial well-being

5.5.1 The additive effects of job demand, control, and support on general job satisfaction.

A hierarchical multiple regression was performed to determine if the addition of control and support improved the prediction of job satisfaction over and above job demands alone. All assumptions for conducting the test were met, details of which can be found in Appendix C16ii. Table 5.6 provides the results of each regression model.

The model that included only job demands (Model 1) was statistically significant, $R^2 = .151$, $F(1, 629) = 111.95$, $p<.001$, adjusted $R^2 = 0.150$. The addition of job control (Model 2) led to a statistically significant increase in R^2 of .024, $F(3,627) = 136.29$, $p<.001$. The addition of support to the prediction of job satisfaction (Model 3) also led to a statistically significant increase in R^2 of .011, $F(4,626) = 162.10$, $p<.001$. The full model of job demands, support and control to predict job satisfaction (Model 3) was statistically significant, $R^2 = 0.509$, $F(4, 626) = 162.10$, $p<.001$, adjusted $R^2 = 0.506$.

Model 1, which included job demands, explained 15% of the variance in general job satisfaction. Model 2, with the addition of job control, explained a further 24% of the variance. The final multivariate model, including demands, control and support, explained 51% of the variance in general job satisfaction.

Table 5.6. Hierarchical multiple regression predicting general job satisfaction from job demands, control and support

	Model 1				**Model 2**				**Model 3**			
	B	*SE B*	*ß*	*t*	*B*	*SE B*	*ß*	*t*	*B*	*SE B*	*ß*	*t*
Demands												
Time and Workload Management	-3.29	0.31	-0.39	**-10.58*****	-0.46	0.34	-0.01	-0.13	-0.45	0.31	-0.05	-1.46
Control												
Bureaucratic restrictions					-4.76	0.34	-0.61	**-14.17*****	-2.93	0.34	-0.37	**-8.64*****
Instructional limitations					-0.40	0.48	-0.03	-0.83	-0.80	0.44	-0.07	-1.81
Support												
Lack of professional supports									-5.15	0.43	-0.48	**-12.06*****
R^2	0.151				0.395				0.509			
F	**111.95*****				**136.29*****				**162.10*****			
ΔR^2	0.151				0.244				0.114			
ΔF	**111.95*****				**126.18*****				**145.38*****			

Note. n=631, using SLPSI subscales for predictor variables, GJSS scale for outcome variable.

****p*<.001

In the final model, two factors made significant contributions to job satisfaction. The most significant predictor of poor general job satisfaction was *Lack of Professional Support* (*ß* = -0.48*, t* = -12.06*, p*<.001). In addition, the amount of control (*Bureaucratic Restrictions*, i.e., control regarding administrative policies, CPD and service delivery) that a respondent had at work had a significant impact on satisfaction (*ß* = *-0.*37*, t* = -8.64*, p*<.001). Both of these factors are composite variables combining individual items. Both factors were therefore further investigated by entering the individual scale items as predictor variables, with job satisfaction as the outcome variable. Assumption testing is detailed in Appendix C16iii.

For job satisfaction (measured by the GJSS) as the outcome variable, the model was statistically significant: R^2 = .60, adjusted R^2 = .59, F (16,612) = 58.344, p<.001. Table 5.7 shows the contribution of the individual items to the GJSS.

Three elements of the SLPSI Bureaucratic Restrictions subscale that assesses the control that an SLT has over their work made a significant negative contribution to job satisfaction. They were: feeling unable to meet one's professional needs (*ß* = -0.19, *t* = -4.366, *p*<.001), lacking control over service delivery models (*ß* = -0.12, *t* = -3.810, *p*<.001), and lacking continuous professional development opportunities (*ß* = -0.09, *t* = -2.468, *p*<.05).

In addition, five elements of the Lack of Professional Support subscale contributed negatively and significantly to job satisfaction. They were: not feeling like a member of the team where one works (*ß* = -0.13, *t* = -4.050, *p*<.001), not feeling that the public values the work that an SLT does (*ß* = -0.141, *t* = -4,387, *p*<.001.), receiving an inadequate salary (*ß* = -0.10, *t* = -3.483, *p*<.01), lacking sufficient resources (*ß* = -0.07, *t* = -2.091, *p*<05), and lacking support (*ß* = -0.03, *t* = -6.724, *p*<.001).

Table 5.7. Multiple regression analysis of bureaucratic restrictions (control) and lack of professional support to job satisfaction

	General Job Satisfaction Scale			
	B	*SE B*	*ß*	*t*
Bureaucratic restrictions				
Administrative policies limit professional growth & effectiveness	-0.348	0.204	-0.058	-1.704
Unable to meet professional needs at work	-1.125	0.258	-0.189	**-4.366***
Lacks control over service delivery models	-0.682	0.179	-0.122	**-3.810***
Lacks continuing professional development opportunities	-0.508	0.206	-0.089	**-2.468***
Lacks emotional and intellectual stimulation	-0.315	0.217	-0.045	-1.453
Lack of professional support				
Doesn't feel like a member of the team in the setting where works	-0.827	0.204	-0.131	**-4.050***
Lacks recognition from other professionals	-0.409	0.240	-0.055	-1.703
Feels other professionals do not understand the work of an SLT	-0.053	0.208	-0.008	-0.254
Feels the public doesn't value the work that an SLT does	-0.912	0.208	-0.141	**-4.387***
Lacks adequate space in which to work	-0.088	0.164	-0.016	-0.539
Experiences poor professional interactions	-0.388	0.256	-0.050	-1.513
Lacks support	-1.683	0.250	-0.269	**-6.724***
Lacks opportunity for promotion/advancement	-0.009	0.168	-0.002	-0.051
Lacks opportunities to consult with other SLTs	-0.112	0.204	-0.019	-0.547
Receives an inadequate salary	-0.485	0.139	-0.098	**-3.483**
Lacks sufficient resources	-0.391	0.187	-0.067	**-2.091***
R^2		**.60***		

* *p*<.05, ** *p*<.01, *** *p*<.001

5.5.2 The interactive effects of job demand, control, and support on general job satisfaction.

Following the investigation of the additive effects of demand, control and support on job satisfaction, the interactive effects of these three contributors to job satisfaction was examined. A second hierarchical multiple regression analysis was conducted to inspect these effects. Assumption testing is reported in Appendix C16iv.

The model that included job demands, control and support individually (Model 1) was statistically significant, $R^2 = 0.527$, $F(3, 623) = 231.70$, $p<.001$, adjusted $R^2 = 0.527$. The addition of the two-way interactions between job demands, control and support (Model 2) led to a statistically significant increase in R^2 of .008, $F(6,620) = 119.06$, $p=.014$. The further addition of the three-way interaction between job demands, control and support in predicting job satisfaction (Model 3) did not lead to an increase in $R^2 = 0.535$, $F(7,619) = 101.90$, $p=.856$. The full model of the interaction between job demands, support and control to predict job satisfaction (Model 3) was not statistically significant, $R^2 = 0.54$, $F(7, 619) = 101.90$, $p=.856$, adjusted $R^2 = 0.530$.

Model 1, which included job demands, explained 53% of the variance in general job satisfaction. Model 2, with the addition of job control explained a further 1% of the variance. The final multivariate model explained 54% of the variance in general job satisfaction.

Analysis of the contribution of individual predictor variables to job satisfaction revealed that in the final model (Model 3), both job control ($ß$ = -.29, $p<.001$) and support ($ß$ = -.49, $p<.001$) made significant contributions to job satisfaction. The interaction between job demands, control and support was not significant in predicting job satisfaction ($ß$ = -.01, $p=.856$). Addition of the three-way interaction in Model 3 did not significantly improve the prediction ($\Delta F = .03$, p=856). Table 5.8 presents the results of this analysis.

Table 5.8. The interactive effects of job demand, control and support on job satisfaction

		GJSS				
		ß	R^2	*F*	ΔR²	ΔF
1	Demands	-.03				
	Control	**-.30*** **				
	Support	**-.51*** **	.527	**231.70*** **	.527	**231.70*** **
2	Demand	-.01				
	Control	**-.29*** **				
	Support	**-.50*** **				
	Demands x control	-.03				
	Demands x support	-.01				
	Control x support	-.06	.535	**119.06*** **	.008	**3.56* **
3	Demands	-.01				
	Control	**-.30*** **				
	Support	**-.49*** **				
	Demands x control	-.03				
	Demands x support	-.02				
	Control x support	-.06				
	Demands x control x support	.01	.535	**101.90*** **	.000	.03

Note. n=631
**p*<.05, ****p*<.001

5.5.3 The additive effects of job demand, control and support on general biopsychosocial well-being.

Next, a hierarchical multiple regression was conducted to determine if the addition of control and support improved the prediction of general biopsychosocial well-being over and above job demands alone. Details of assumption testing are outlined in Appendix C16v. Table 5.9 provides details on each regression model.

The model that included only job demands (Model 1) was statistically significant, R^2 = 0.172, $F(1, 615) = 127.60$, $p<.001$, adjusted R^2 = 0.170. Addition of job control (Model 2) led to a statistically significant increase in R^2 of .031 $F(3,613) = 52.13$, $p<.001$. The addition of support to the prediction of general biopsychosocial well-being (Model 3) also led to a statistically significant increase in R^2 of .030, $F(4,612) = 46.49$, $p<.001$. The full model of job demands, support and control to predict general biopsychosocial well-being (Model 3) was statistically significant, R^2 = 0.233, $F(4, 612) = 46.49$, $p<.001$, adjusted R^2 = .228.

Model 1, which included job demands, explained 17% of the variance in general biopsychosocial well-being. Model 2, with the addition of job control, explained a further 3% of the variance. The final multivariate model explained 23% of the variance in general biopsychosocial well-being.

Table 5.9. Hierarchical multiple regression predicting general biopsychosocial well-being from job demands, control and support

	Model 1				**Model 2**				**Model 3**			
	B	*SE B*	*ß*	*t*	*B*	*SE B*	*ß*	*t*	*B*	*SE B*	*ß*	*t*
Demand												
Time and Workload Management	6.48	0.57	0.42	**11.30*****	4.38	0.73	0.27	**5.84*****	3.82	0.73	0.24	**5.27*****
Control												
Bureaucratic restrictions					2.94	0.72	0.20	**4.07*****	1.21	0.79	0.08	1.52
Instructional limitations					0.85	1.03	0.04	0.82	0.25	1.04	0.01	0.24
Support												
Lack of professional supports									4.87	1.00	0.25	**4.99*****
R^2	0.172				0.203				0.233			
F	**127.60*****				**52.13*****				**46.49*****			
ΔR^2	0.172				0.031				0.030			
ΔF	**127.60*****				**12.10*****				**23.77*****			

Note. n=617, using SLPSI subscales for predictor variables, GHQ-28 scale for outcome variable
***p<.001

In the final model, two factors made significant contributions to general biopsychosocial well-being: *Time and Workload Management* (*ß = 0.*24*, t* = 5.27*, p*<.001) and *Lack of Professional Support* (*ß* = *.*25*, t* = 4.99*, p*<.001). Both of these factors are composite variables combining individual items. Both were therefore further investigated by entering the individual scale items as predictor variables, with the GHQ-28 score as the outcome variable. For general biopsychosocial well-being (measured by the GHQ-28) as the outcome variable, the model was statistically significant: R^2 = .30, adjusted R^2 = .28, F (19,597) = 13.40, p<.001.

Two elements of the *Time and Workload Management* subscale (assessing job demands faced by SLTs) made a significant negative contribution to job satisfaction. They were: not having enough time to get work done (*ß* = .123, *t* = 2.193, *p*<.05), and having no time to relax (*ß* = .154, *t* = 3.376, *p*<.001).

In addition, three elements of the *Lack of Professional Support* subscale contributed negatively and significantly to job satisfaction. They were: not feeling like a member of the team where one works (*ß* = .123, *t* = 2.815, *p*<.01), feeling that the public doesn't value the work of an SLT (*ß* = .148, *t* = 3.341, *p*<.001) and lacking support (*ß* = .204, *t* = 3.863, *p*<.001).

Table 5.10. Multiple regression analysis of demand (Time and Workload Management) and lack of professional support to general biopsychosocial well-being (GHQ-28)

	General Health Questionnaire - 28			
	B	*SE B*	*ß*	*t*
Time and Workload Management				
Too much work to do	-1.017	.763	-.080	-1.333
Not enough time to get tasks done	1.526	.696	.123	**2.193***
Little time to prepare adequately for sessions	-.477	.594	-.038	-.802
Little time for personal work targets	.523	.580	.044	.902
Caseload is too big	.537	.527	.054	1.020
No time to relax	1.865	.552	.154	**3.376*****
Easily overcommitted	.695	.616	.057	1.128
Too much paperwork	.836	.513	.071	1.629
Lack of professional support				
Doesn't feel like a member of the team in the setting where works	1.453	.516	.123	**2.815****
Lacks recognition from other professionals	.624	.600	.045	1.041
Feels other professionals do not understand the work of an SLT	.247	.529	.021	.467
Feels the public doesn't value the work that an SLT does	1.790	.536	.148	**3.341*****
Lacks adequate space in which to work	-.530	.421	-.049	-1.257
Experiences poor professional interactions	.191	.652	.013	.293
Lacks support	2.394	.620	.204	**3.863*****
Lacks opportunity for promotion/advancement	-.677	.389	-.072	-1.738
Lacks opportunities to consult with other SLTs	-.312	.511	-.028	-.611
Receives an inadequate salary	-.084	.350	-.009	-.239
Lacks sufficient resources	.115	.462	.011	.250
R^2		**.28*****		

* p<.05, ** p<.01, *** p<.001

As well as producing a total score of biopsychosocial well-being, the four subscales of the GHQ-28 yield scores for components of well-being, namely: somatic symptoms, anxiety and insomnia, social dysfunction and depression. Table 5.11 shows the correlational relationships between job demands, control and support, and each of the four subscales.

Table 5.11. Correlations between the psychosocial work environment and the GHQ-28 subscales

	Demands	**Lack of control**	**Lack of support**
GHQ Somatic symptoms	.304***	.303***	.338***
GHQ Anxiety & Insomnia	**.438****	**.410****	**.413****
GHQ Social dysfunction	.351***	.344***	.373***
GHQ Depression	.216***	.176***	.210***

****p*<.001

All three psychosocial dimensions were significantly correlated with all four GHQ-28 subscales, at the p<0.001 level. Those that had moderate correlations with GHQ-28 subscales are highlighted in bold font. Demands (r = .438), control (r = .410) and support (r = .413) were all moderately correlated with anxiety and insomnia. Demands, control and support were therefore entered as predictor variables in separate multiple regression analyses, using the GHQ-28 anxiety scores as the outcome variable.

The model was statistically significant R^2 = .242, adjusted R^2 = .239, F (3,612) = 65.253, p<.001. Table 5.12 shows the multiple regression analysis between demands, control and support and anxiety and insomnia scores.

Table 5.12. Multiple regression analysis of demands, control and support with anxiety

	GHQ-28 Anxiety & Insomnia			
	B	*SE B*	*ß*	*t*
Demands	**1.749**	**.297**	**.270**	**5.880*** **
Lack of control	.772	.452	.094	1.709
Lack of Support	**1.699**	**.407**	**.207**	**4.172*** **
R^2			**.24*** **	

***p<.001

While a lack of control did not have a significant influence on anxiety and insomnia (p=0.088), both demand and a lack of support did. Both of these dimensions on the SLPSI (*Time & Workload Management* and *Lack of Professional Support*) are composite variables, containing individual items. To establish which of these individual items had the most significant influence on anxiety and insomnia, each were entered as predictor variables in a multiple regression using *GHQ-28 Anxiety and Insomnia* as the outcome variable.

The model was statistically significant $R^2 = .298$, adjusted $R^2 = .276$, F (19,596) = p<.001. Table 5.13 reports the associations between these individual items and the *GHQ-28 Anxiety and Insomnia* subscale.

Table 5.13. Multiple regression analysis of the relationships between demand, support and anxiety and insomnia

	GHQ-28 Anxiety & Insomnia			
	B	*SE B*	*ß*	*t*
Demand (Time and Workload Management)				
Too much work to do	-.165	.315	-.031	-.522
No time to get tasks done	**.729**	**.288**	**.142**	**2.533****
Little time to prepare adequately for sessions	-.049	.246	-.009	-.199
Little time for personal work targets	.064	.240	.013	.266
Caseload is too big	.128	.218	.031	.585
No time to relax	**.819**	**.228**	**.164**	**3.586*****
Easily overcommitted	.334	.255	.066	1.311
Too much paperwork	.113	.212	.023	.533
Lack of Support				
Doesn't feel like a member of the team in the setting where works	.337	.214	.069	1.574

Lacks recognition from other professionals	-.064	.248	-.011	-.256
Feels other professionals do not understand the work of an SLT	.102	.219	.021	.466
Feels the public doesn't value the work that an SLT does	**.610**	**.222**	**.122**	**2.744****
Lacks adequate space in which to work	-.273	.174	-.062	-1.565
Experiences poor professional interactions	.481	.270	.079	1.779
Lacks support	**.823**	**.257**	**.188**	**3.545*****
Lacks opportunity for promotion/advancement	-.213	.161	-.055	-1.326
Lacks opportunities to consult with other SLTs	-.021	.211	-.005	-.098
Receives an inadequate salary	-.091	.145	-.024	-.625
Lacks sufficient resources	.254	.191	.056	1.329
R^2			**.30*****	

** $p<.01$, ** $p<.001$

From the *Time and Workload Management* subscale, both a lack of time to get tasks done ($ß = .142$, $t = 2.53$, $p<.01$) and no time to relax ($ß = .164$, $t = 3.59$, $p<.001$) made statistically significant contributions to anxiety and insomnia. From the *Lack of Support* subscale, feeling that the public doesn't value the work that an SLT does ($ß = .122$, $t = 2.74$, $p<.01$), and generally lacking support ($ß = .188$, $t = 3.55$, $p<.001$) made statistically significant contributions to anxiety and insomnia.

5.5.4 The interactive effects of job demand, control and support on general biopsychosocial well-being.

Further to the examination of the additive effects of job demand, control and support on biopsychosocial well-being, the interactive effects of these contributors was investigated. Results of assumption testing are described in Appendix C16vi.

The model that included job demands, control and support individually (Model 1) was statistically significant, $R^2 = 0.232$, $F(3, 613) = 61.62$, $p<.001$, adjusted $R^2 = 0.228$. The addition of the two-way interactions between job demands, control and support (Model 2) led to a statistically significant increase in R^2 of .014, $F(6,610) = 33.09$, $p<.001$. The further addition of the three-way interaction between job demands, control and support in predicting general biopsychosocial well-being (Model 3) also led to a small, but statistically significant increase in R^2 of 0.002, $F(7,609) = 28.56$, $p<.001$. The full model of the interaction between job demands, support and control to predict biopsychosocial well-being (Model 3) was statistically significant, $R^2 = 0.247$, $F(7, 623) = 28.56$, $p<.001$, adjusted $R^2 = 0.239$.

Model 1, which included job demands, explained 23% of the variance in general job satisfaction. Model 2, with the addition of job control explained a further 1.4% of the variance. The final multivariate model explained 25% of the variance in general biopsychosocial well-being

Analysis of the contribution of individual predictor variables to general biopsychosocial revealed that in the final model (Model 3), both job demands ($ß = .29$, $p<.001$) and support ($ß = .26$, $p<.001$) made significant contributions to biopsychosocial well-being. However, the interaction between job demands, control and support was not significant in predicting biopsychosocial well-being ($ß = -.058$, $p=.256$). Addition of the three-way interaction in Model 3 did not significantly improve the prediction ($\Delta F = 1.29$, $p=.256$). Table 5.14 presents the results of this analysis.

Table 5.14. The interactive effects of job demand, control and support on biopsychosocial well-being

		ß	R^2	*F*	ΔR^2	ΔF
1	Demands	**.24*****				
	Control	.07				
	Support	**.25*****	.232	**61.62*****	.232	**61.62*****
2	Demand	**.27*****				
	Control	.07				
	Support	**.24*****				
	Demands x control	.04				
	Demands x support	.09				
	Control x support	-.001	.246	**33.09*****	.014	**3.74***
3	Demands	**.29*****				
	Control	.07				
	Support	**.26*****				
	Demands x control	.04				
	Demands x support	.07				
	Control x support	.002				
	Demands x control x support	-.058	.247	**28.56*****	.002	1.29

Note. n=617
*$p<.05$, ***$p<.001$

5.6 The mediating effect of individual differences on the relationship between the psychosocial work environment and occupational well-being

The mediating effects of dispositional traits on the relationship between the psychosocial work environment and general job satisfaction was investigated. First, the dispositional traits across the four retained JDCS groups are described. These included the four core self-evaluations (self-esteem, generalized self-efficacy, locus of control and negative affect) and optimism.

5.6.1 Dispositional traits of participants in four job types.

Table 5.15 describes the dispositional traits across the four job types.

Table 5.15. Mean core self-evaluation and optimism scores across the four retained job types

	Self-esteem M (*SD*)	**Self-efficacy M (*SD*)**	**Locus of Control M (*SD*)**	**Negative Affect M (*SD*)**	**Optimism M (*SD*)**
Group 1: Active Collective (*n*=237)	7.16 (1.73)	7.76 (1.39)	7.36 (1.38)	3.44 (1.88)	7.10 (1.76)
Group 2: Low Strain Collective (*n*=154)	7.76 (1.70)	8.26 (1.35)	7.95 (1.22)	2.72 (1.72)	7.90 (1.70)
Group 3: High Strain Collective (*n*=105)	6.61 (2.34)	7.04 (1.84)	6.90 (1.72)	4.31 (2.08)	6.45 (2.14)
Group 4: IsoStrain (*n*=97)	6.10 (2.32)	6.90 (2.05)	6.24 (1.81)	5.04 (2.22)	5.80 (2.10)

5.6.2 The multiple mediation model: Job satisfaction.

Further exploration of the data was conducted to evaluate whether dispositional traits had a mediating effect on the relationship between the type of job a participant holds and their job satisfaction. This relationship is depicted in Figure 5.3.

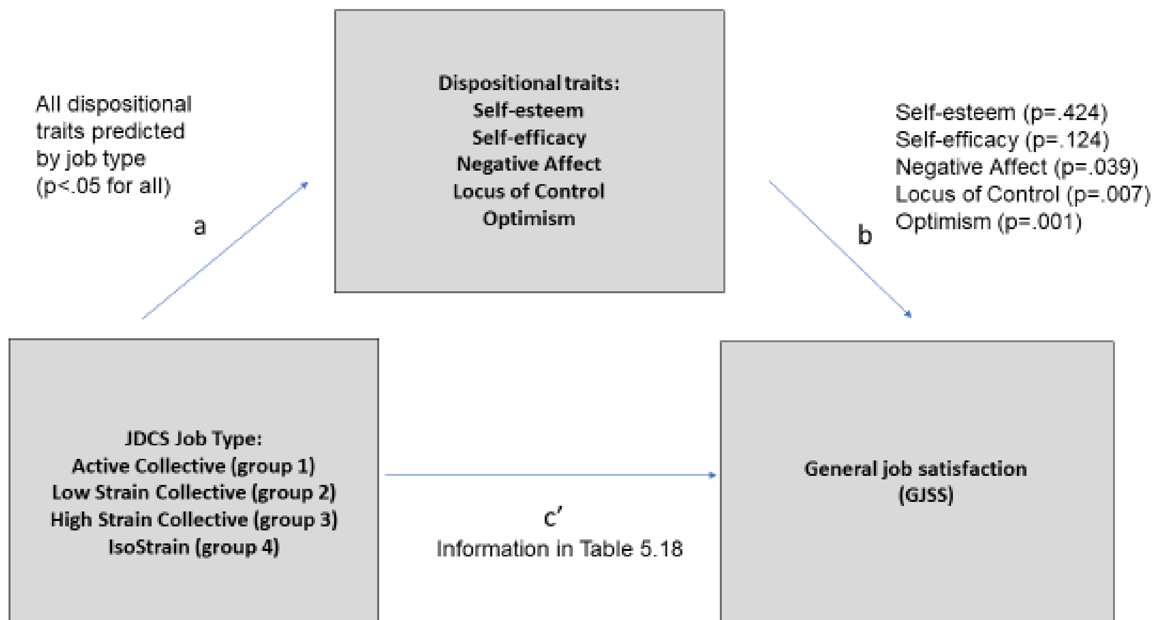

Figure 5.3. The mediating effect of dispositional traits on the relationship between JDCS job type and general job satisfaction

Key:
a=the effect of job type on dispositional traits
b=the effect of dispositional traits on job satisfaction
c'=the effect of job type on job satisfaction, mediated by dispositional traits

Multiple mediation analysis revealed that, overall, the job type predicted the levels of all the dispositional traits explored: self-esteem, self-efficacy, negative affect, and optimism. It also predicted locus of control. Table 5.16 presents the prediction of the level of dispositional traits by job type.

Table 5.16. Prediction of level of dispositional trait by job type

Dispositional trait	**Job type**	***b***	**95% LCI**	**95% UCI**	***t***
Self esteem	X1	0.60	0.203	0.995	**2.97****
	X2	-0.55	-0.999	-0.102	**-2.41***
	X3	-1.06	-1.518	-0.596	**-4.50*****
Self-efficacy	X1	0.49	0.166	0.813	**2.97****
	X2	-0.73	-1.092	-0.359	**-3.89*****
	X3	-0.87	-1.243	-0.490	**-4.52*****
Negative affect	X1	-0.72	-1.110	-0.322	**-3.57*****
	X2	0.97	0.425	1.317	**3.84*****
	X3	1.60	1.140	2.057	**6.85*****
Optimism	X1	0.97	0.414	1.176	**4.10*****
	X2	-0.65	-1.085	-0.222	**-2.97****
	X3	-1.30	-1.741	-0.835	**-5.74*****
Locus of control	X1	0.59	0.288	0.891	**3.84*****
	X2	-0.46	-0.805	-0.122	**-2.67****
	X3	-1.12	-1.472	-0.770	**-6.27*****

Note. X1=Active collective v Low Strain Collective, X2=Active collective v High Strain Collective, X3=Active collective v IsoStrain effect
*=p<.05, **=p<.01, ***=p<.001

Job satisfaction was in turn predicted by negative affect, locus of control and optimism, but not self-esteem or self-efficacy. Table 5.17 depicts the direct effect of dispositional traits on job satisfaction.

Table 5.17. Effect of dispositional traits on general job satisfaction

Dispositional trait	**GJSS**			
	b	95% LCI	95% UCI	*t*
Self esteem	0.16	-0.183	0.435	0.80
Self-efficacy	0.18	-0.624	0.075	-1.54
Negative affect	-0.14	-0.557	-0.014	**-2.06***
Optimism	0.15	0.188	0.779	**3.21****
Locus of control	0.18	0.136	0.848	**2.71****

Note. LCI= Lower Confidence Interval, UCI-Upper Confidence Interval
*=p<.05, **=p<.01, ***=p<.001

5.6.3 The overall mediating effects of dispositional traits on the relationship between job type and job satisfaction.

Overall, dispositional traits mediated the relationship between job types and job satisfaction. Results are presented in Table 5.18.

Table 5.18. The mediating effect of dispositional traits on the relationship between job type and job satisfaction

	c (job type predicting job satisfaction)[a]	**c' (including mediators)[a]**
X1	*b* = 1.78, 95% CI [.72, 2.83], t = 3.30, ***p* = .001**	*b* = 1.07, 95% CI [.05, 2.10], t = 2.05, ***p* = .040**
X2	*b* = -4.86, 95% CI [-6.06, -3.66], t = -7.97, ***p* < .001**	*b* = -4.23, 95% CI [-5.40, -3.07], t = 7.15, ***p* <.001**
X3	*b* = -9.43, 95% CI [-10.66, -8.20], t = -15.03, ***p* < .001**	*b* = -8.00, 95% CI [-9.23, -6.76], t = -12.73, ***p* < .001**

Note. X1=Active collective v Low Strain Collective, X2=Active collective v High Strain Collective, X3=Active collective v IsoStrain effect, [a]mediation is said to have occurred if the value of b for c' is smaller than that for c (i.e., the relationship between the predictor variable and the outcome variable has been partly explained by including the mediators)

Identifying specific mediators (job satisfaction)

Comparing groups 2, 3, and 4 to group 1, negative affect, optimism and locus of control all mediated the relationship between job type and job satisfaction. Self-esteem and self-efficacy did not mediate the relationship. Table 5.19 shows the effects of mediation on the relationship between job type and job satisfaction. It is assumed that for those confidence intervals that don't contain zero (highlighted in bold text), the indirect effect is probably greater than 'no effect', indicative of mediation having occurred.

Table 5.19. Specific dispositional traits that mediate the relationship between job type and job satisfaction

Mediator	Comparison	Effect	Bootstrap LCI	Bootstrap HCI
Self-esteem	X1	.151	-.057	.430
	X2	.139	-.405	.058
	X3	.266	-.742	.098
Self-efficacy	X1	.109	-.329	.076
	X2	.161	-.123	.457
	X3	.193	-.132	.589
Negative Affect	X1	.304	**.091**	**.561**
	X2	-.370	**-.711**	**-.096**
	X3	-.678	**-1.235**	**-.225**
Locus of Control	X1	.358	**.129**	**.659**
	X2	-.282	**-.583**	**-.048**
	X3	-.682	**-1.184**	**-.273**
Optimism	X1	.058	**.018**	**.111**
	X2	-.048	**-.105**	**-.009**
	X3	-.096	**-.178**	**-.024**

Note. *X1=Active collective v Low Strain Collective, X2=Active collective v High Strain Collective, X3=Active collective v IsoStrain*

5.7 Comparison of well-being outcomes for participants across employment sectors

5.7.1 Job types across employment sectors.

Employment sectors in which the participants worked were analysed to determine the distribution of the JDCS model job types of those who were organizationally employed, those who were self-employed and those who worked in both sectors. Because the NHS is a large employer of SLTs, analysis of NHS employees was also included. The majority of self-employed clinicians had Low-strain jobs (54%, n=31), whereas those who were organizationally employed were more likely to have Active (42%, n=226) or High-strain (35%, n=187) jobs. Most respondents who worked in both sectors had High-strain jobs (42%, n=16). Figure 5.4 displays the JDC classification of jobs across employment sectors.

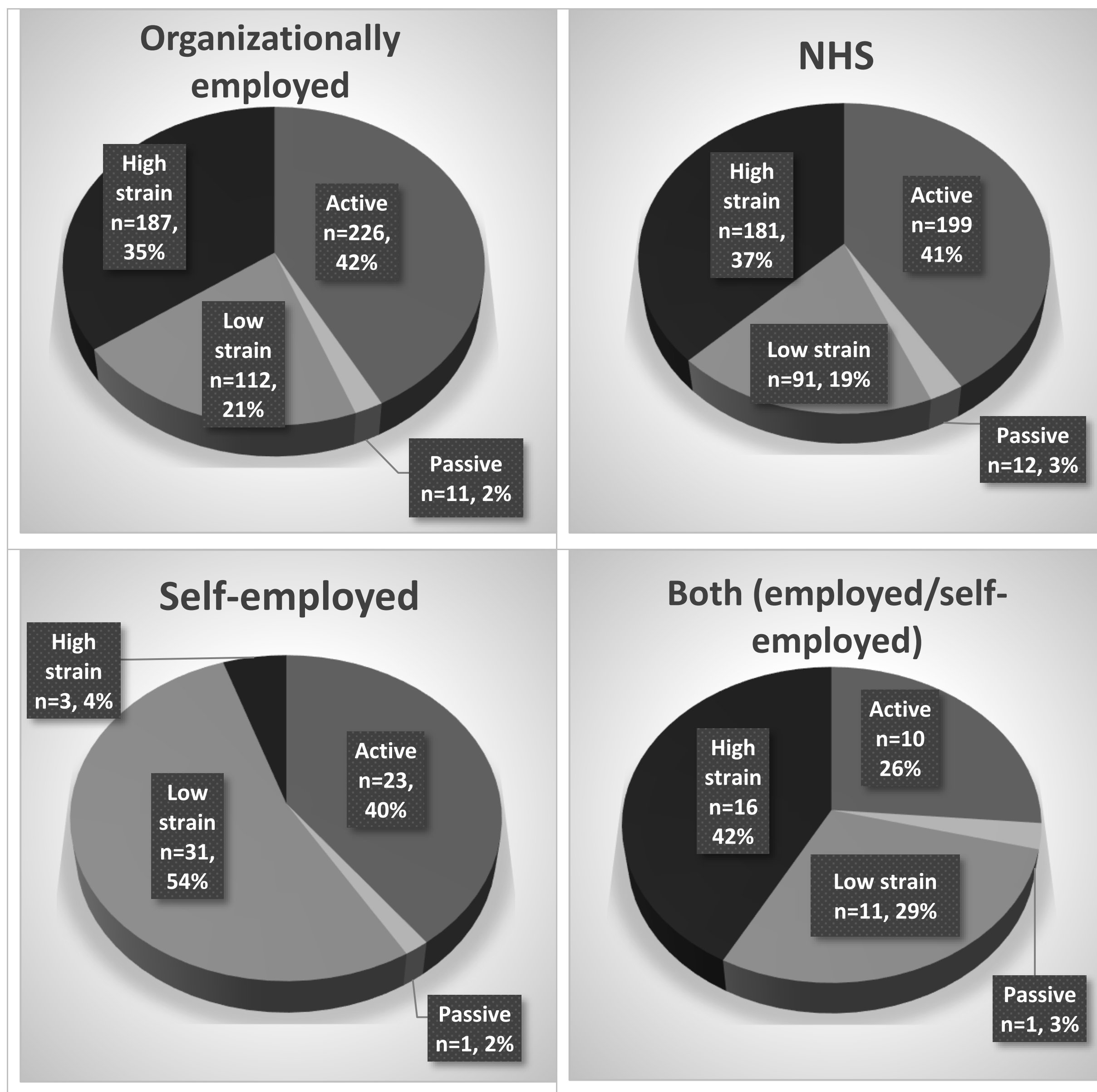

Figure 5.4. JDCS classification across employment sectors

5.7.2 Well-being across employment sectors.

The well-being of participants who were organizationally employed, those who were self-employed and those who worked in both sectors was compared.

Job satisfaction (GJSS scores), stress (SLPSI scores) and general biopsychosocial well-being (GHQ-28 scores) were all assessed. Participants who were self-employed had higher job satisfaction scores, lower stress scores and better general biopsychosocial well-being than respondents in the other two groups. Table 5.20 presents mean scores and standard deviations for the three groups.

Table 5.20. Well-being scores across different employment types

Employment type	GJSS *M (SD)*	SLPSI *M (SD)*	GHQ-28 Total *M (SD)*	% achieving caseness
Self-employed (*n*=58)	40.53 (5.51)	2.30 (0.44)	18.83 (10.39)	34%
Organizationally employed (*n*=536)	35.95 (6.41)	2.75 (0.48)	24.38 (12.26)	55%
Both[a] (*n*=38)	35.03 (7.50)	2.64 (0.54)	23.35 (9.81)	60%

Note. n=632, [a]participant was partly organizationally employed and partly self-employed

A one-way multivariate analysis of variance (MANOVA) was conducted to determine whether these differences were statistically significant. Full details of the preliminary assumption checking, and the methods used to deal with violations can be found in Appendix C161vii.

The differences between the groups on the combined dependent variables was statistically significant, $F(6, 1226) = 7.994$, $p<.001$, Pillai's Trace = .075, partial $\eta^2 =.038$. The effect size was small.

Follow-up univariate ANOVAs showed that GJSS scores ($F(2,614) = 12.008$, $p<.001$, partial $\eta^2 =.038$), SLPSI scores ($F(2,614) = 20.574$, $p<.001$, partial $\eta^2 =.063$) and GHQ-28 ($F(2,614) = 4.069$, $p<.05$, partial $\eta^2 =.013$) scores were statistically significantly different between the three groups.

Games-Howell post-hoc tests showed that for GJSS scores, self-employed participants had statistically significantly higher mean scores than participants from either the employed ($p<.001$) or 'both' ($p<.01$) groups, but the difference between the employed and 'both' groups was not significant ($p=.88$). For SLPSI scores, the self-employed group had statistically significantly lower mean scores than the employed ($p<.001$) and 'both' ($p<.05$) groups. Again, the difference between the employed and the group who worked in both sectors was not significant ($p=.33$). Finally, self-employed participants had statistically significantly lower GHQ-28 scores (i.e., better biopsychosocial well-being) than the employed ($p<.05$) group but not the group who worked in both sectors ($p=.34$). The

difference between the employed and those who worked in both sectors was not significant (p=.713).

Participants were also asked, when all things were considered, how happy they were in their current jobs, and the mean scores for each employment sector were compared. Table 5.21 reports the mean scores.

Table 5.21. The mean scores for happiness in the three different employment groups

Employment type	Overall happiness *M (SD)*
Self-employed (n=58)	8.64 (1.33)
Organizationally employed (n=535)	7.13 (2.08)
Both[a] (n=38)	6.92 (2.08)

Note. [a]participant was partly organizationally employed and partly self-employed

A one-way analysis of variance (ANOVA) revealed statistically significant differences between scores, $F(2, 628) = 15.01$, $p<.001$. Games-Howell post-hoc tests revealed a statistically significant difference between participants who were self-employed and those who were organizationally employed ($p<.001$), between those who were self-employed and those who worked in both sectors ($p<.001$) but not between those who were organizationally employed and those who worked in both sectors ($p=.82$).

Finally, participants were asked whether their job was worthwhile or not. Fisher's Exact Test was performed to establish statistically significance of any differences across employment sectors. All those (58/58 SLTs) who were self-employed felt that their jobs were worthwhile, compared to 97% (619/535) of those who were organizationally employed, and 95% (36/38) who worked across both sectors. Groups were not statistically different ($p=0.23$).

5.8 Comparison of job satisfaction and general biopsychosocial well-being at T1 and T2.

There were 295 paired responses at T2. Firstly, changes in job satisfaction and general biopsychosocial well-being across the whole group were compared. Table 5.22 reports mean scores.

Table 5.22. GJSS scores and GHQ-28 scores for T1 and T2

GJSS, n=286 M (*SD*)		GHQ-28, n=283 M (*SD*)	
T1	T2	T1	T2
37.07 (6.40)	37.59 (6.14)	21.52 (10.20)	21.98 (10.10)

A paired samples t-test revealed that the increase in GJSS score across time was statistically significant, t (285) = -2.04, p=.04. However, the increase in the GHQ-28 score across time was not statistically significant, t (282) = -0.89, p=.37. Assumption testing is described in Appendix C16viii.

Asked whether they were still in the same job as they had been at T1, 275 (93%) of the 295 respondents said that they were. Participants were also asked whether they had made any positive personal changes. Of those who responded, 135 people (46%) had made a change, of which 134 were positive. The one that was negative reported taking work home to combat the stress of being unable to complete her work during allocated hours. Some positive changes were work-related, such as consciously modifying an attitude (e.g., "*no longer putting pressure on myself*") or no longer engaging in leaveism (e.g., "*no longer taking work home*") and others concentrated specifically on health and well-being (e.g., "*started an exercise programme*" or "*mindfulness activities*"). Further examples of the changes made between T1 and T2 are presented in Appendix C22. Four subgroups were created:

i. Those who were in the same job and had made no personal changes
ii. Those who were in the same job but had made a positive personal change
iii. Those who had left their job but made no personal changes
iv. Those who had left their job and made a positive personal change

Table 5.23 reports comparisons of the GJSS scores and GHQ-28 scores for subgroups at both time points.

Table 5.23. Comparisons of GJSS and GHQ-28 scores for subgroups at T1 and T2

GROUP (*n*)	**GJSS**			**GHQ-28**		
	T1 GJSS Score *(SD)*	T2 GJSS Score *(SD)*	Mean Difference	T1 GHQ-28 Score *(SD)*	T2 GHQ-28 Score *(SD)*	Mean Difference
Same job (*n*=275)						
Same job, no personal change (*n*=153)	37.25 (6.58)	37.61 (5.85)	.36	20.79 (9.81)	21.36 (10.25)	0.57
Same job, personal change (*n*=122)	37.06 (6.47)	37.36 (7.08)	.30	24.34 (12.57)	22.76 (10.18)	-1.58
Left job (*n*=20)						
Left job, no personal change (*n*=7)	36.00 (7.18)	37.17 (15.79)	2.83	20.00 (13.04)	16.43 (5.43)	-3.57
Left job, personal change (*n*=13)	32.00 (6.12)	37.42 (5.20)	5.42	28.38 (15.87)	21.15 (9.48)	-7.23

Note. n=295

5.8.1 The impact of change on job satisfaction and general biopsychosocial well-being.

A three-way mixed multiple analysis of variance (MANOVA) was conducted to explore the effects of a change of job and/or positive personal changes on job satisfaction (GJSS scores) and general biopsychosocial well-being (GHQ-28 scores). The three independent variables were therefore time (T1 & T2), job (same or not) and positive personal change (or lack thereof). The two dependent variables were the GJSS score and GHQ-28 score.

Assumption testing is reported in Appendix C16ix. Job satisfaction will be discussed first, followed by general biopsychosocial well-being.

5.8.1.1 Job satisfaction.

Changes in job satisfaction were analysed for 292 respondents (three participants who had left their jobs were no longer working). The three-way interaction between time, job changes and positive personal changes was not statistically significant for job satisfaction, $F(1, 284) = .532$, $p=.47$, partial $\eta^2 = .002$.

There was no statistically significant two-way interaction between time and positive personal changes on GJSS scores, $F(1, 284) = .478$. $p = .49$, partial et $\eta^2 = .002$. However, there was a statistically significant two-way interaction between time and job changes on GJSS scores, $F(1,284) = 8.07$, $p=.005$, partial $\eta^2= .028$. The difference in GJSS scores between T1 and T2 for the two groups ('remained in job' v 'left job') was therefore explored in more detail. Table 5.24 reports the mean job satisfaction scores for the two groups at T1 and T2.

Table 5.24. Mean job satisfaction scores at T1 and T2 for those who changed jobs & those who remained in their jobs

	Mean GJSS score (*SD*)[a]	
	T1	T2
Same job (*n*=275)	37.16 (6.52)	37.50 (6.41)
Different job (*n*=17)	33.06 (6.67)	37.88 (5.77)

[a]scores between 32 and 38 denotes 'average' job satisfaction

First, t-tests were used to explore the difference in job satisfaction between the two groups at T1, and then at T2. Assumption testing is presented in Appendix C16x. At T1, SLTs who later remained in their jobs had higher GJSS scores (M = 37.16, SD = 6.52) than those who later left their jobs (M = 33.06, SD = 6.67), and this difference was statistically significant, $t(292) = 3.285$, $p=.001$. At T2, there was an improvement in GJSS scores for both the SLTs who had left their previous jobs (M = 37.88, SD = 5.77) and those who remained (M = 37.50, SD = 6.41) but the difference in GJSS between the two groups at T2 was not statistically significant, $t(290) = -.241$, $p=.81$.

Finally, the difference in job satisfaction for each group across time (i.e., between T1 and T2) was explored. Only seventeen participants had changed jobs between T1 and T2, meaning the sample size for this group was small. For these seventeen respondents, there was a statistically significant increase in job satisfaction, $t(16) = -3.225$, $p<.01$. For those who were in the same job at the two time points ($n=275$), there was not a significant change, $t(274) = -1.09$, $p=.28$. Figure 5.5 illustrates the changes in GJSS scores for the two groups over time, with the graph focusing specifically on the 'average' band of the GJSS.

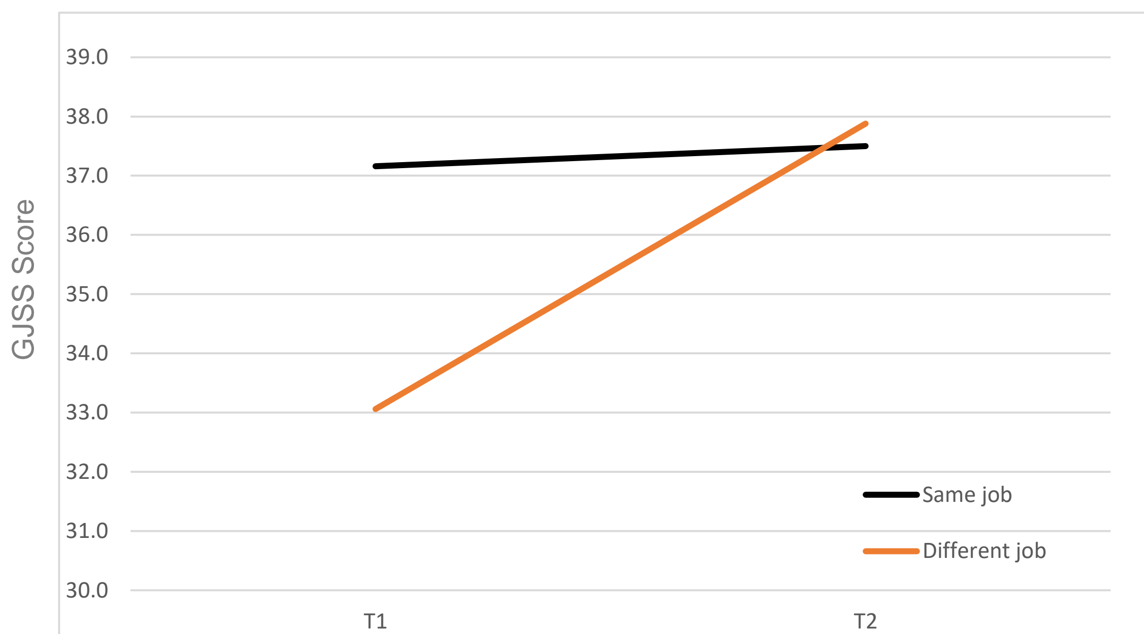

Figure 5.5. Changes in job satisfaction over time, for SLTs who remain in their jobs and those who leave and start new jobs

5.8.1.2 General biopsychosocial well-being.

There was no statistically significant three-way interaction between time, job changes and positive personal changes for general biopsychosocial well-being, $F(1,284) = .058$, $p = .81$, partial $\eta^2 = .000$. There were also no statistically significant interactions between time and positive personal changes, $F(1, 284) = 1.04$, $p = .31$, partial $\eta^2 = .004$, or between time and job changes, $F(1,284) = 1.882$, $p = .17$, $\eta^2 = .007$.

5.9 Summary of Inferential Results

SUMMARY

1. SLTs surveyed in this study experience similar levels of overall stress to the original cohort of SLTs in the USA who completed the SLPSI (Fimian, 1991).
2. Regarding elements of stress, the current participants experienced less control in their jobs but more professional support than the original cohort. This sample also reported a greater incidence of stress symptoms, including physical, behavioural and emotional manifestations of stress.
3. Comparing JDCS job types, those with IsoStrain jobs had the lowest job satisfaction scores and the worst general biopsychosocial well-being scores. In contrast, those who held Low-strain Collective jobs had the highest job satisfaction and experienced relatively better biopsychosocial well-being.
4. There were significant correlations between all elements of the psychosocial workplace (i.e., demands, control and support) and all outcomes (occupational stress, job satisfaction and general biopsychosocial well-being).
5. Support for the additive effect of the JDCS model was found, for both job satisfaction and general biopsychosocial well-being.
6. Control and support were statistically significant in predicting job satisfaction.
7. Feeling unable to meet one's professional needs, lacking control over service delivery models, and lacking continuous professional development opportunities all contributed negatively towards job satisfaction.
8. Not feeling like a member of the team, receiving an inadequate salary, lacking sufficient resources and lacking support generally also contributed negatively towards job satisfaction.
9. Demands and support were statistically significant in predicting general biopsychosocial well-being.
10. Specifically, anxiety and insomnia were predicted by a lack of time (both to get tasks done and to relax), by feeling that the public doesn't value the work that an SLT does, and by generally feeling unsupported.
11. The interactive effects of the JDCS model were not found to predict either job satisfaction or general biopsychosocial well-being.
12. Negative affect, optimism and locus of control all mediated the relationship between job type and job satisfaction.
13. Self-employed participants had higher job satisfaction, lower occupational stress, and better biopsychosocial well-being than those who were organizationally employed or held a mixture of both types of employment.
14. Participants who changed their jobs had better job satisfaction at the time of the second survey than they had reported at the time of the first survey.
15. Positive personal changes (e.g. starting a mindfulness programme) did not result in a change in reported job satisfaction over three months.
16. For this sample, general biopsychosocial well-being was consistent over a three-month period of time.

The questionnaire at T1 of Phase One included an open-ended question, which yielded qualitative data that supplemented quantitative findings. The next section presents the qualitative analysis of this data.

5.10 Qualitative Content Analysis

Qualitative content analysis sought to expand upon the findings of the quantitative phase of the study. Of the 162 responses to the open-ended question examined, 55 participants mentioned demand, 17 discussed control and 34 mentioned support. Loving the job was referred to by 25 respondents, and 51 remarked on stress. Biopsychosocial, as well as behavioural consequences of stress, were acknowledged. In addition, some respondents discussed feeling misunderstood/undervalued, others referred to how their personalities or personal lives contributed to stress, and several wrote about how their values sometimes did not match those of their employers. Phase two of this study explored the themes confirmed in this first qualitative content analysis; as well as possible novel themes identified here. The full analysis is therefore not included here, to ensure parsimony, but is provided in Appendix D1. An extract of that analysis is presented here, as an illustration:

One comment, by a respondent who was employed by an independent special school, gave a sense of the complexity inherent in the way psychological and social well-being is influenced by the combination of personal and work factors:

> *"Whilst I am happy in my job, I am not content in my personal life and find both often influence each other. I procrastinate all the time about most personal and professional activities and often don't want to leave my house once I get home. I feel this is because I need wind down time but also as I don't want to face or interact with groups of people once I've finished work. I don't have a lot of friends in the area, and this also gets me down/contributes to me staying in in the evenings. I feel anxious about my personal life most of the time and this has a moderate influence on my mood at work although I tend to mask it by acting upbeat, which in itself is tiring. I do not feel depressed but certainly anxious and possibly over conscientious, hence working over-time. I do exercise 3 or 4 times a week which I feel is beneficial mentally and physically. However, I have come to the conclusion that seeking professional counselling/psychological advice would be beneficial for my personal mental health and well-being. This is something I am currently looking in to. I love being a SALT and being part of the SALT community e.g. CENS, colleague discussions. I feel I need to figure out the work/life balance a bit better though in order to make (sic) more productive with my time" (ID269).*

The SLT who provided this statement commented on her feelings about her personal life and her work, how these domains influenced one another, how she attempted to look after her well-being (through exercising) and what she would do to address what she viewed as problematic. She was explicit regarding the concerns she had about her life outside work, stating she was '*not content'* and was '*anxious*' about her personal life. This contrasted with her statements regarding work – initially she asserted that she was '*happy*' at work, and later she said, "*I love being a SALT*". There is evidence, however, that work may have influenced her home life, affecting her ability to engage socially in her community. She stated that she procrastinated '*all the* time' – a possible symptom of stress – and that she worked overtime (although she attributed this to being anxious and '*possibly over conscientious'*). She also reported that she did not want to leave the house once she got home; and felt the reason for this was that she needed to '*wind down'* and that she did not want to '*face or interact with groups of people*' once she had finished work. The use of the phrase '*wind down*' implies that work left her feeling anxious or strained. The reasons for her anxiety therefore appear to be more complex than at first reading. Work was possibly partially responsible for her anxiety, with the nature of work resulting in her not wanting to go out, possibly contributing to her procrastination and to her worrying about her personal life. At the end of the statement, she indicated that work may be contributing to her difficulties, by saying that she needed to '*figure out the work/life balance'*.

5.10.1 Summary of qualitative content analysis.

Over 25% of all respondents (n=162) left comments in response to the open-ended question. SLTs in this sample viewed themselves as professional, competent, confident and committed. They took pride in their work, and some assumed responsibility for negative feelings that they had. There appeared to be a degree of conflict between this assumption of responsibility and the role that work played in shaping their feelings. There was also evidence that SLTs had some appreciation of the complexity in the way that home life and work life interacted to influence their well-being.

It is always prudent to be cognisant of non-response bias (Dixon and Turner, 2007) as respondents who have no complaints might be less likely to comment than those who are unhappy. Analysis of the responses for this sample revealed both positive and negative comments about being an SLT. Some respondents loved their jobs, while others commented on the pressures and stresses of the profession. There appeared to be clear differences between SLTs who were employed and those who were self-employed, with the self-employed SLTs generally leaving more positive comments. However, these details do not negate the possibility of non-response bias, which should be taken into account when considering results.

Demands mainly took the form of workload (e.g., caseload) but also included emotional demands. Self-employed SLTs appeared to find it easier to be in control of the demands that they faced than their organizationally employed colleagues. Support for SLTs in this sample varied considerably. Of concern to some SLTs was that they were not understood; and felt undervalued. Allied to this was concern regarding remuneration. Finally, SLTs in this sample shared various physical, psychological, social and behavioural responses to feeling stressed. Chief amongst these was anxiety, and the main behavioural response was to leave the NHS.

The qualitative data from the first questionnaire lent some support to the quantitative findings, confirming that demands and support are issues of importance to SLTs in the UK, but that dispositional traits may play a role in the relationship between work elements and well-being. Furthermore, the open-ended question allowed for expansion into topics that the quantitative questions did not fully exploit. The primary areas that were novel were SLTs' views of themselves, thoughts about responsibility for well-being, and an indication that SLTs might experience conflict regarding their values or ideals and what they were able to do at work. These areas were therefore further explored in the second phase of this project, the results of which are presented in the following chapters.

CHAPTER SIX: FINDINGS FROM THE IDEOGRAPHIC PHASE OF THE STUDY (INTERVIEWS)
SUPERORDINATE THEME ONE

6.1 Overview of the Qualitative Analysis

Twelve subthemes were identified in the analysis of the 15 interviews that were conducted. Interviewee profiles are provided in Appendix E1. The 12 subthemes were organised into five superordinate themes:

1. Being a speech and language therapist
2. The daily working life of a speech and language therapist
3. A lack of validation, feeling unsupported
4. Feeling conflicted, being in control
5. Looking after well-being: success and challenges

The structure of the superordinate themes and subthemes is presented in Table 6.1.

Table 6.1. Superordinate themes and subthemes

Superordinate Theme	Subtheme
1. Being a Speech and Language Therapist	1a. Love and Pride
	1b. Values and Beliefs
	1c. Feeling Responsible
2. The daily working life of a Speech and Language Therapist	2a: Daily working life – too much to do
	2b: Emotional demands and consequences
	2c: Ensuring a service was income generating
3. A lack of validation, feeling unsupported	3a: The profession is not understood
	3b: SLTs don't feel valued
	3c: The need to justify the profession, and one's own existence
	3d: Support – formal supervision and informal support
4. Feeling conflicted, being in control	4a: Conflicting expectations
	4b: A lack of control
	4c: Consequences of a lack of control
	4d: Resolving conflict: strategies used
5. Looking after well-being - Success and challenges	5a: Taking responsibility for well-being
	5b: Personal resilience to support well-being
	5c: Stress and its consequences

This chapter discusses the first super-ordinate theme. The four chapters that follow discuss themes two, three, four and five. Each theme is described using extracts from the interview transcripts, which appear in italics in the grey shaded sections. These illustrate the participants' experiences in their own words and provide evidence for the themes. Figure 6.1 describes the transcription notation used for individual extracts.

- …. = text omitted because it did not add to the example
- ( ) = explanatory text added by the researcher when quote unclear e.g. use of 'it' refers to e.g. (the stress)
- [ ] = non-verbal vocalizations and paralinguistic elements of conversation e.g. [laugh] or [pause]
- Bold text = emphasis by participant

The pseudonym of each participant and their employment status are cited following each participant's quote. If self-employed the participant is identified as SE

Figure 6.1. Transcript notation used for quoted interview extracts

6.2 Venues of the Interviews and Presence of Non-participants.

Reading the transcripts, it was not felt that different venues affected the content that participants provided, or their willingness to share experiences and feelings. However, two of the coffee shops were noisy, which affected the quality of the recording and made transcription difficult. It was felt that, despite some sections in both being unintelligible, both transcriptions could be used for analysis.

The presence of non-participants during interviews is discussed here as this may affect an interviewee's responses (Tong, et al., 2007). When interviews took place at participants' homes or places of work, non-participants were not present. The restaurant where one interview was conducted was large, and a booth that was not near any other customers was selected, meaning that non-participants could neither overhear the interview, nor see the researcher and participant. The five remaining interviews took place in coffee shops. Three of these were large, which allowed the interview to take place away from other customers. The last two were smaller, and both were busy. During one, the participant occasionally referred to noise levels and waited for the noise to die down before continuing to speak. In the second, the researcher had to ask the participant to repeat herself at times.

It is not possible to say whether the presence of non-participants affected the content of the participants' responses.

6.3 Overview of Superordinate Theme One: Being a Speech and Language Therapist

This super-ordinate theme describes how SLTs love what they do and are proud of their profession. They are clear about what they love, which centres around their daily interaction with service-users – the ability to 'be a therapist'. Furthermore, their work is underpinned by the beliefs and values that they hold: being of service to others, belief in client-centred care, and belief in the right to healthcare. Finally, their experiences of being SLTs is characterised by a feeling of responsibility, for services that they deliver and to service-users themselves. All the participants contributed to this theme. Similarities and differences across the employed and self-employed sub-groups are discussed.

Superordinate Theme One	Subthemes
Theme One: Being a Speech and Language Therapist	1a. Love and Pride 1b. Values and Beliefs 1c. Feeling Responsible

6.4 Subtheme 1a: Love and Pride

All the participants interviewed expressed positive emotions related to being an SLT. These feelings were expressed using terms such as 'love' and 'passion'. Participants described enjoying what they did, and they were proud of the work they do. These positive feelings were evident across both the employed and self-employed SLTs. Some, such as Hendre and Willow, used repetition to reinforce their feelings.

"I am passionate about our jobs, our profession, our roles…I just love the job. I love, love, love the job. I always have." (Hendre, NHS)

"I love being a speech and language therapist. I absolutely love it. I always look forward to going to work in the morning." (Willow, SE)

"I get really passionate about it…it's a very fulfilling career." (Sally, SE)

The main reason that both employed and self-employed participants gave for loving the work they do was being able to interact with, build relationships with, and support service-users, their families and other professionals. In short, this may be termed ‘being a therapist’ – as Lesley described it. The notion of ‘being a therapist’ is key when attempting to understand the meaning that SLTs give to their experiences. It is a point which threads through future themes – relating both to what SLTs value and to the threats to their well-being. While this particular subtheme concentrates on the positive result of being able to ‘be a therapist’, other themes will illustrate that if this clinical aspect of the job is, for whatever reason thwarted, values are compromised; and well-being is threatened.

For Lesley, ‘being a therapist’ led to feelings of pride, providing insight into how building therapeutic relationships is linked to fulfilment and regard. Her repetition of the word ‘love’ is an indication of her strength of feeling when talking about her work. Both she and Ruby referred to the ‘clinical’ aspect of the job, and Lesley went on to explain that she enjoyed the ‘intervention’ side of the work. Positive feelings that stemmed from being a therapist were also linked to the ability to affect change, which was described by Alice as ‘making a difference’. This ability to ‘make a difference’ is further explored in the next subtheme, when discussing ‘being of service to others’.

“I’m a speech and language therapist because what I love is speech and language therapy – I love working with the kids, that is why I do it…being a therapist is what I love doing…I feel really proud of what I do… I love the clinical side of work. I love my day-to-day work; I love the children that I work with. I enjoy the contact with parents and with teachers…I feel good about being a speech and language therapist.” (Lesley, SE)

*“…I think the way that I’m working now is very clinically satisfying and **that** is why I can still say that I enjoy it.” (Ruby, SE)*

“Yeah, usually good. Something that I would say – pride, I think it’s a career that helps people, um, so, yeah, I no, I generally like being a speech and language therapist.” (Isabella, SE)

“I like working with children. I like having sessions with the children – hands on, you know, getting in there, doing activities with them, um, you know – they’re funny, they’re great.

And I like trying to work out, you know, what is the matter, what's going on with them. And I like trying to communicate that to parents – trying to support them. Um, yeah, trying to help them see what they can do, to help their child." (Anne, NHS)

"I really like it, I work with adults and I love having that [sighs] sort of – adult conversations with people, having a bit of a laugh, but you know, there's a serious side to it as well, so. I think it's a good mix, so I enjoy it, yeah." (Jan, NHS)

"Things I love about the job? Well, I love my patients. I like spending time with my patients and being able to do something that makes a difference to somebody…" (Alice, ex-NHS)

Reasons for loving the job also included the hybrid nature of the career. Explaining what attracted her to speech and language therapy, Jo discussed the profession combining '*psychology, linguistics and science'* as well as '*working with people'*. Later on, when asked how she felt about being an SLT, she referred back to this, talking about the '*essence*' of the job – something intrinsic to the work that does not focus on the practicalities of carrying out that job.

"*I still love the essence of the job and what brought me to it." (Jo, NHS)*

For others, their love for the job was not absolute, but was tempered by feeling discouraged or exhausted. Arguably, this might reflect typical employment in other careers – with some elements of work leading to positive feelings and others less so. However, of concern is that, for some – such as Carol – the negative elements of the job eventually dominated, meaning she left a profession that she had loved.

"Sometimes I feel like it's like the best thing and other times I'm just completely worn out…" (Gwenneth, NHS)

"I loved it. I really did…working with the families, working with the children, was great. It was the other stuff that started to get me down in the end. But I loved being a speech and language therapist." (Carol, ex-NHS, ex-SLT)

Susan's account added to the evidence that loving elements of a job does not necessarily equate with an overall feeling of enjoying it. While she appreciated the support that she received from her colleagues, her statement, '*I love it, even though it's so horrific'* alludes to some conflict in her feelings. Her choice of the word '*horrific*' provides some insight into how awful she feels the job can be, and the juxtaposition with '*love*' is arresting. This conflict will be further explored in the third superordinate theme, 'Conflict and Control.'

"And I love working where I work. I've just been complaining about it a lot but the reason I love it, even though it's so horrific, [laughs] is because it's really supportive. It's so nice." (Susan, NHS)

6.5 Subtheme 1b: Values and Beliefs

Three common and distinctive representations of the values and beliefs that participants hold were apparent in their accounts: Being of service to others, belief in client-centred care and belief in the right to healthcare that is free at the point of access. These were consistent across both sub-groups, although there was some difference in the way that they were articulated.

6.5.1 Being of service to others.

Being of service to others was expressed in terms of 'making a difference' for them. Alice returned to the notion of making a difference three times, viewing this as a core driving force that provided her with a fundamental reason for working as an SLT. This fostered positive feelings about being an SLT. Alice's comments were echoed by Sally and Lesley, who also discussed making a difference.

"Well, I love my patients. I like spending time with my patients and being able to do something that makes a difference to somebody. That's undoubtably… why you get up in the morning and go to work, isn't it?... And feeling like you can do something really small that makes a really big difference to how they live their life… At the moment I feel really good about being a speech and language therapist, because I, I really like to do something that makes other people feel better. Or different." (Alice, ex-NHS)

"I think, I love that it's challenging and that it's genuinely a career where you can help people and see the difference that you make, um, not just for the children that I work with but also for their families, um, and the confidence that you see in people growing and things like that. I just love that." (Sally, SE)

"I think, for me, a ***huge*** *part of my well-being is about making a difference." (Lesley, SE)*

Positivity engendered through having affected change was expressed, not only in terms of the emotional element of well-being, e.g., 'loving it', but in terms of its cognitive component, 'satisfaction'. In addition to satisfaction, Willow felt that a further consequence of making a difference was feeling that the activity was useful. These two constructs contributed to a sense of utility.

"I have a big sense of satisfaction, when I feel like I've helped the families." (Susan, NHS)

"…certainly, there is some job satisfaction in working with the children and in, from time to time, seeing them improve [laughs]." (Anne, NHS)

"For me it was very important to go into something where I would be adding value… I feel like I'm making a difference, that I'm positively contributing something to society. Um, so yeah, I feel useful," (Willow, SE)

Knowledge of having made a difference did not always originate from self-reflection, but sometimes depended on the responses of service-users, as conveyed by Gwenneth:

"I do get nice feedback from families and you can come away and think, 'Wow, I've really helped make a difference there.'" (Gwenneth, NHS)

However, when this ability to affect change was obstructed, well-being was threatened. During Anne's description of the changes to her working life over time, she discussed her ambivalence about being an SLT and how her feelings about her career had deteriorated over time, alongside her diminishing ability to make a difference. Sally added to this picture of a changing environment, which resulted in frustration and stress.

"(In the past) I felt, definitely, much better about it. I felt that I was making a difference to children's lives, I felt that parents appreciated what I was doing, um, you know, obviously there were complex cases but, um, at that time, we didn't have such pressures on the service...things have really changed…" (Anne, NHS)

"So, for me, a lot of stress came from knowing – I supposed I'd worked… at a time in the NHS when I was still able to do the job, in my opinion, properly, so that I could see that I was affecting change. I could see that I was contributing, my, seeing me meant something. For this family or this child. Um, and then to go from that, to this, was very frustrating." (Sally, SE)

6.5.2 Client-centred care.

Alongside wanting to make a difference, was the belief that any intervention provided by an SLT should be determined by what service-users need, and that service-users should be central to decisions made. This is likely to be a value that is instilled during training, reflecting the social model of care that is currently dominant in SLT education. More than half of the participants in each group referred to this. Hendre, talking about the imposition of targets and the strategies for meeting them, felt that service-users became lost in the process, which frustrated her. For Willow, the inability to practice client-centred care was one of the reasons she left the NHS, and she returned to the importance of putting the patient first when discussing the reasons she enjoyed being self-employed.

*"**So** frustrated… you know, where's the patient in all of this? Where's the patient's voice in all of this? Was what was really difficult for us." (Hendre, NHS)*

"I felt that patients were not at the centre anymore, of what we were doing." (Willow, SE, explaining why she decided to leave the NHS)

*"The things that I enjoy… (doing) things that are **patient**-centred." (Willow, SE, talking about working as a self-employed SLT)*

Gwenneth, talking about senior managers who have no patient contact, made the following point:

"You forget, you know, why are we planning this service? I'm planning this service because that boy that I saw on Monday morning would really benefit if the service worked this way, or that child on the waiting list who's Request for Assistance form I vetted yesterday, would really benefit. If you don't have that patient contact, you forget." (Gwenneth, NHS)

Ensuring that one's practice is client-centred, however, takes place within the context of other demands – while these will be elaborated on in the next theme, 'The daily working life of an SLT', they were touched upon by Pamela, when she discussed a particular client with whom she worked, and shared some of the skills that she was required to employ to ensure that the client remained central to the process and the other services with whom she worked were facilitated to ensure this. Her account alluded to the complexity of the work that SLTs carry out:

"I'm very family focused, so, um, you often get a situation where there's a sort of – a provider who's supporting an individual will blame the family? Where I don't think that's at all helpful. But it does sit you between the provider and the family sometimes and that's a difficult place to be, because you have, you have to be a diplomat, you have to be a negotiator, you have to be a go-between, and all the time you're trying to focus on this individual's needs and actually, how best should we all [laughs, trails off]" (Pamela, NHS)

There was acknowledgement that NHS services did not always facilitate client-centred care, but SLTs were committed to enabling it, as discussed by Kathryn and Jo, who both described developments that led to improvement.

"Following specific guidelines to do with stroke… we were not able to see a lot of people that didn't fit into certain criteria… we've been commissioned to see more people so we've become very flexible and very patient-centred and it's patients' needs-led." (Kathryn, social enterprise)

"…you know, goal-setting has become very institutionalised and sort of imposed on people. And (the approach currently being used where I work) is about really keeping that person at the centre of what you do…" (Jo, NHS)

In contrast, the self-employed SLTs' accounts of being client-centred tended to reflect their capacity to respond to need without the service constraints imposed when employed (e.g., a limited number of therapy sessions). Because self-employed SLTs were able to respond to need they had a level of control regarding service delivery. Further details regarding the differences in control between those who are organizationally employed and those who are self-employed will be discussed in the fourth superordinate theme; 'Feeling conflicted, being in control'.

"So if I feel a child needs ongoing intervention for me to be able to deliver my service in the best possible way; that is what I will recommend." (Lesley, SE)

"…if I perceive a need and if I feel that there's actually a way that I can actually support a child to make gains, and if their family are happy to fund that, then we can make it happen." (Ruby, SE)

6.5.3 Belief in the right to healthcare.

Also evident in the accounts of participants was a belief in the right of people to receive the healthcare they need regardless of financial position. Despite choosing not to work in the NHS, the self-employed SLTs' accounts were explicit in this viewpoint. Willow, Lesley and Sally all described how, now that they were self-employed – and therefore charged their clients for the service that they provided – they experienced conflict about doing so. The accounts by the self-employed SLTs alluded to a sense of cost/benefit to their well-being with regards to working for the NHS or not: working as self-employed SLTs, they made gains which will be further explored in the themes three, 'A lack of validation, feeling unsupported' and four, 'Feeling conflicted, being in control' but there was also a cost in terms of conflict regarding their values.

"I wanted to do something more public sector. That was important to me…I think maybe that's also why I give away a lot, why I do, I sit on a lot of committees, and I do a lot of free work, because that sits better with my conscience [laughing]." (Willow, SE)

"I actually struggle with the fact that I charge people for my services." (Lesley, SE)

"Morally, it felt wrong because I feel that the NHS is the service that everybody can have, and it's bad that I'm keeping everything, all the skills that I've gained, and my expertise, which had been honed in the NHS, under other NHS therapists. And I'm taking that away now from my local area. Um, it felt really bad. Um, and I felt bad that only people who are well off enough can afford that now. Do you know what I mean?" (Sally, SE)

Those employed in the NHS articulated this viewpoint differently. For them, the ability of people to access healthcare regardless of financial position was realised specifically through the NHS, and they acknowledged that there were personal gains for them in being employed by the NHS, in terms of their feelings about themselves. These feelings included pride, and a sense of altruism, as evidenced in the following exchange with Jan. Jan appeared to think carefully about what she enjoyed about being an NHS employee, her exhalations during the following exchange appeared to be because she did not find it easy to articulate her feelings of pride.

Jan: *I think it's that sort of lovely…sort of community you get from the NHS and the nice feeling you get from it. Um [exhales] I don't know. I guess it's more of like a sentimental thing. Um, it just feels good to work for the NHS.*

Claire: *What's good about it? Tell me more about that.*

Jan: *Um, I don't know, just like I guess it's like a feeling of pride really. Like feeling proud to work for the NHS…it just [exhales] it just, yeah, feels like you're, you're there for everyone and it's not for your, even though, if you, if you work in the private sector it's not for your gain. But it feels a bit more selfless. I guess. I don't know.*

Jo's account also alluded to a sense of altruism, which she described as '*serving*'. For Jo there was a sense of her awareness of her role in community, and the '*give and take'* nature of being in that community. Jo's need to serve was linked to a sense of duty to the NHS because her training had been paid for by the health service, and to a feeling that families appreciated her '*serving*'.

"I still want to serve, in a sense, you know – the NHS paid my fees and it, you feel you're serving the community, um, and you know, families are often so grateful for that bit of input." (Jo, NHS)

One participant, Susan, articulated how working in the NHS aligned with her political views and allowed her to feel superior to those with different views – although she was self-critical of this feeling. Her account suggested that working in the public sector was not always pleasurable for her, but that her sense of activism, of being a person who did not accept the status quo and was prepared to voice her dissatisfaction, kept her there.

"I feel a bit political about it, you know. It's the NHS and I'm working with autistic people and I've got big, strong opinions about how we see autism in our society. Um, yeah, and I feel like it's a way that I can, like, express my political views. Like through being at work. (Working in the NHS) just feels fair. It feels like you're doing something, morally it feels nice. And also, I like a sense of, this is horrible, I feel like a bit superior? Because [inhales deeply] um, so every day I go to work and at some point, I go, 'This is awful, I hate the NHS, I'm going to leave.' And then I think, 'Well, it can't just be left with the people that find it acceptable.' Do you know what I mean? That would be terrible [laughs]." (Susan, NHS)

While not explicitly stated, these accounts of pride, of community, and of moral superiority all alluded to a belief that the SLTs are participating in a service that is 'right', and an underlying belief that healthcare should be available to all, regardless of their financial situation.

Finally, Pamela made the point more broadly. While she did not mention the NHS, she added to the concept by including the argument that profiting from people's vulnerability is wrong.

"…this is one of my biggest soapbox things. I'm not a very political person, but – I think it should be illegal to profit out of money that you get to look after vulnerable adults, or children." (Pamela, NHS)

6.6 Subtheme 1c: Feeling Responsible

Ten of the fifteen participants discussed responsibility. A sense of duty and obligation was present across both those who were employed and those who were self-employed. SLTs felt a responsibility to service-users as well as for the way a service was delivered and managed.

Pamela's statement about a service-user being referred '*to me'* is an indication of how this feeling of personal responsibility for clients becomes ingrained in the way an SLT views her role and her relationship with a service-user. Pamela did not distance herself from the service-user, meaning the responsibility for his well-being lay not with the service more generally, but specifically with her.

> "*He was referred to me, or to us, sorry, to us." (Pamela, NHS)*

Pamela wondered whether being 'responsible' was an aspect of her personality, but acknowledged that it was a professional trait, part of her professional identity. For her, taking responsibility for service-users was a core feature of the job, without which one could not practise compassionately, but which also resulted in personal suffering. By linking responsibility with compassion, she provided an insight into the meaning that SLTs gave to this construct. For them, responsibility went beyond the roles, functions and competencies for which an employee is typically accountable and extended to the duty of care that encompasses a moral obligation to ensure the well-being of service-users.

> *"You know, you feel like, because you have a sense of responsibility, because you're a, you have a - well, maybe it's a personality thing, but it's also a professional thing, and I don't know how you really separate the two things out properly, we talked about identity. You have a responsibility, and you can't easily switch that off. It's really hard to switch that off. People that can do that, I think they might not suffer as much, but I'm not sure they're as good, in terms of their compassion and their commitment." (Pamela, NHS)*

Pamela:	*I think there's personal standards – um – that we believe in. Self-beliefs.*
Claire:	*That's an interesting word – belief.*
Pamela:	*It is, it is, it's strong. And it is a powerful thing and I think unless it was, you wouldn't – you wouldn't suffer for it [laughs].*

Jan shared an experience where she needed to advise an MDT regarding the management of a service-user's difficulties. Her account involved supporting a patient with a profound language difficulty to be able to communicate a life-changing decision that needed to be made within a short period of time. Having the responsibility for enabling this patient to accurately share wishes that would substantially alter her life course was, for Jan, '*horrible*'. It is possible that this was due to her realisation that she was in a position to substantially influence the life of the service-user.

"'Cos all of the team were like literally looking to me about, 'Well, Jan can like – [laughs] – 'Tell us what to do. What do we do?' And it was like, 'I don't, I don't, I don't know, like this is such…', and yeah, she had like…It was horrible. And she only had like two weeks to decide, or something…That, that was really stressful, feeling like I had all of that pressure on me and, like I said, all the MDT sort of looking to me for the answer. Was really hard." (Jan, NHS)

The impact on the SLT of bearing this responsibility – that (as Pamela, above, stated) they '*suffer*,' was further illuminated in Carol's account, who discussed worrying, and how this worry did not end when the working day ended. Kathryn used the phrase '*huge burden'* when talking about responsibility, adding to impression that SLTs carried a significant emotional load as a result of the duty they felt to service-users. This emotional load will be further explored in the next theme, 'The daily working life of an SLT'.

'Because, because you know that that family trusts you and therefore you feel responsible. So, you feel responsible. So, you can't go home at the end of the day and forget about it all. You know, it's the sort of thing that you take home with you, and you worry." (Carol, ex-NHS, ex-SLT)

I think sometimes there are times when we cannot help people but we kind of expect ourselves to sort it all out. And that's become the norm and it's accepted and part of speech therapy. And sometimes it's not always right to keep doing that but there's maybe a fear that we'll get it wrong if we don't carry on and try and sort out this person's problems…. It's a huge responsibility, a huge burden. (Kathryn, social enterprise)

Like Kathryn, Ruby referred to having significant responsibility as an accepted part of the role of an SLT. The language that she used – '*messing with people's lives'* – suggested an awareness of the discrepancy in power that existed between SLTs and service-users, and that decisions made by SLTs could be life-changing. Ruby's comment provides some insight into how having this amount of influence resulted in feelings of carrying substantial responsibility. Her comments corroborate those of Jan's above, who felt the burden of responsibility when supporting a service-user through a life-changing decision.

"I think that there's an expectation that you will just absorb your responsibility to make a difference to somebody's ***actual*** *life; that we are messing with people's lives essentially…" (Ruby, SE)*

Isabella explained how she felt overburdened by responsibility – it '*weighs on'* her – as a result, she felt she was never doing enough. This had a negative impact on her job satisfaction, she felt she was failing the service-users which, for her, was awful. Her use of the word '*failing*' carries negative connotations, and '*horrible*' suggests an extremely unpleasant experience.

"I feel like it's never enough, I feel like you're never doing enough, you're never meeting the needs of all the children. And that weighs on you, you know, that kind of that personal thing. So sometimes there isn't the job satisfaction necessarily that you would want because there's always some kid who you haven't been able to get to for a term, or whatever, um, uh, and just, yeah, I just think the caseloads are quite high. And, yeah. Like when I, at one school in particular I'm often just sort of like, 'Oh, we're failing these children.' And that's a horrible feeling." (Isabella, SE)

The accounts of other participants added to the evidence that SLTs in the sample felt a responsibility towards the well-being of service-users. Jo related how the desire to fulfil this responsibility was strong enough to override her own perceived capacity in terms of

workload, resulting in her experiencing a sense of burden. Her feelings of responsibility were combined with a lack of control over her workload and over the demands that she felt she must respond to, which link to themes two, 'The daily working life of an SLT' and four, 'Feeling conflicted, being in control'.

"(The ward staff will) say, 'Oh, I think so-and-so's ready for an upgrade, um, can you just see them today?' And you're thinking, 'Well, no, I can't really. But actually, Joe Bloggs, you know, he's going to obviously have much better quality of life if we can get him off of puree, and perhaps he doesn't need that anymore, but I don't know without seeing him,' so it's, yeah. It's very compelling to try and do more for your patients, isn't it?... There's a lot put on you." (Jo, NHS)

Others were specific regarding feeling responsible for the way in which a service is delivered. SLTs, it seems, might not be able to compartmentalise, or prise apart feelings of responsibility – they assume responsibility for the progress and well-being of their clients, and recognise that this is impacted upon by the way that the service is delivered. This means that, by extension, they feel responsible for service delivery. There is a clear contrast between what SLTs 'should' feel responsible for – according to Gwenneth, who has management responsibilities; and what they actually do feel responsible for – according to Anne, whose role is purely clinical.

"I say to people – you know – you don't need to worry about that, because that's part of my job to worry about that so I can differentiate that, so it might be – you know – when it comes to, I don't know, making decisions about waiting lists… sometimes people can have this idea that they've got to try and solve all the problems where's in fact, they don't." (Gwenneth, NHS)

"I mean, if I could just ignore the wider picture, in the department, maybe I could cope better, but just, you know, when we have our locality meetings and I see that there are, you know, 100 children on the waiting list, and of them, you know, 20 of them have been waiting a year or whatever it is, and I just think, 'What the hell are we doing? This is ridiculous!' And then stuff we're doing, I can't necessarily see that it's working…" (Anne, NHS)

SLTs who were self-employed were also conscious of the responsibility that providing a service carried, and for some this took the form of meeting the need that they or their clients identified. For Isabella, this sense of responsibility meant that the pressure she felt herself to be under was self-imposed. Lesley described the responsibility in terms of an obligation to the schools in which she worked. While she was not employed by the schools (she was employed directly by families), she felt it her duty to ensure the service she provided was responsive to needs identified by schools.

"So, there was a huge need (in a particular school. The person contracting my services) wasn't putting pressure on me; I was putting pressure on myself 'cos I saw all that need." (Isabella, SE)

"…I'm also committed in certain schools so if there are children that they need me to see, I make a plan to fit them in. So, whilst I control my caseload by not taking on anything new outside of my current commitments, within those, um, I don't turn away. Because it's, I'm kind of providing a service to the school." (Lesley, SE)

Ruby described the work that she did as '*setting up a mini-service'* for each child with whom she worked. Her comment, '*It is all me*,' reveals how sole traders are exclusively responsible for every aspect of providing a service. Lesley's account echoes this point. Once more, there is a sense of cost/benefit as both mentioned responsibility and control together.

"I have to create every liaison, sorry every, um, link, every system has to be set up by me. So, there's nobody overseeing my caseload for me, or my timetable or advising me or sending me to that school on that day and this school – there's none of that. I have to do all of that [smiles]. From scratch. It doesn't exist. So actually, it's setting up a mini-service but that service is actually just me. Um, which actually means that okay, I have autonomy to a degree, and I have control over it, but I have absolutely no workforce to do all of it. It is all me." (Ruby, SE)

"I just find it frustrating that I'm doing everything. But then I'm in, you know, I'm in control. So, I know exactly what's going on." (Lesley, SE)

6.7 Summary

In summary, most SLTs had a sense of vocation and were passionate about the work that they did. They had a well-defined and specific sense of what it is that they loved, the core of which was their ability to interact with service-users. Their experience of ‘doing therapy’ or ‘providing intervention’ was interpreted as ‘being’ a therapist. These experiences were aligned to their values, which included being of service to others and patient/client-centred care – where what mattered to service-users was central to the service that was provided. Furthermore, their work was underpinned by their belief in the right to access healthcare regardless of financial status, particularly as it was realised through the NHS. Some derived a sense of their own self-worth by working for the NHS. Those who were no longer working in the NHS still expressed a belief in the right of people to access care that did not discriminate according to financial means. Finally, being an SLT included an awareness of a duty of care to service-users – expressed through the responsibility participants felt for the way in which services were delivered and to service-users themselves.

CHAPTER SEVEN: SUPERORDINATE THEME TWO
THE DAILY WORKING LIFE OF A SPEECH AND LANGUAGE THERAPIST

7.1 Overview of Superordinate Theme Two

This second super-ordinate theme describes participants' views of their daily working lives as SLTs. It includes three subthemes. The first reflects their views that their workloads are overwhelming and incorporates discussion of service issues such as staffing levels, targets and caseload size. In the second, the emotional demands that are placed on SLTs and the consequences of these are considered. Finally, a contrast between the employed and self-employed participants is highlighted – that of the responsibility to ensure a service was income-generating.

Superordinate Theme Two	Subthemes
Theme Two: The daily working life of a Speech and Language Therapist	2a: Daily working life – too much to do 2b: Emotional demands and consequences 2c: Ensuring a service was income-generating

7.2 Subtheme 2a: Daily Working Life – Too Much to Do

All the participants who were interviewed discussed workload as being an issue in their daily working lives. Their general perception was that there was too much to do, with ten SLTs commenting on this. Workloads were perceived to be overwhelming, as described by Gwenneth, and could impact on SLT wellbeing – Pamela felt anxious about the amount of information she was required to process; and a heavy workload resulted in stress for Jan, which led to rumination on her part – '*constantly thinking about'* her to-do list.

"I think that just the sheer amount of work can be quite overwhelming at times and juggling that and managing that work, prioritising... …sometimes on a Sunday night now I get that feeling of, 'Yeugh, I've got work tomorrow' which I never, ever used to have. Years ago, I never had that…I think it's probably because every week it always feels like there's so much to do and so much to juggle and prioritise."" (Gwenneth, NHS)

"We also get masses of information from our trust, our organizations that we work for, from HCPC, it's so disparate. And it's, you just think, I think that adds to the anxiety, 'I've missed

something, I've missed something, I, know I, I know I have because I know I didn't read that, that came through, and I couldn't…' You know, nobody has time…" (Pamela, NHS)

"That's usually the thing that stresses me out – I've got loads of things to do. Um, and it's quite a long list that's building up… (I) just think, 'Oh God, I've got so much to do,' and I find I'm constantly like thinking about my to-do list." (Jan, NHS)

While Susan felt responsible for her own well-being (she had a '*plan*' to look after herself); she felt that workload added to her stress, alluding to the possibility that she had little control over the number of tasks ('*a million*') that she was required to do. Her statement suggests that there might only be so much that an individual can do to take care of their own well-being. Control will be followed up in theme four, 'Feeling conflicted, being in control'.

"I mean, we've all got our plan to look after ourselves, and how to get on with it, but then there's this other level of stress that – okay, well, I've got a million things to do…" (Susan, NHS)

Participants' experience of workload was that it was unremitting. For Jo, the pace of the work resulted in her being unable to process the interactions she had with service-users and in her feeling anxious about whether she had missed information. Sally's account contributed to this sense of feeling overwhelmed by the amount of work and the constant pressures that SLTs faced. When asked whether there were things at work that put her well-being at risk, Sally responded with a detailed description of her daily working life. She began with discussing '*constant change*' – an environment of ceaseless upheaval within the NHS served to underlie everything else with which she had to deal. Daily responsibilities therefore sometimes occurred within a background of continuous change. Kathryn's use of the phrase '*working flat-out'* adds to a depiction of SLTs working as hard and as fast as they can. Finally, Alice's account alluded to the relentless nature of the workload. She described her daily experience – holding a clinical caseload, supporting other clinicians, and not having the time to complete her own work during the day, resulting in her completing work at home in the evenings – and explained that this scenario would repeat itself on a daily basis. This feeling of relentlessness will be returned to when examining participants' comments about resilience in the last, fifth, theme; 'Looking after well-being: success and challenges.'

“You know, Monday to Thursday I work and it’s relentless. You don’t have time to even process what you’ve seen. So, you’re seeing one patient after another, and you come back and you’re thinking, ‘Oh, did I miss something there?’ because there’s so much pressure to see lots of patients.” (Jo, NHS)

“…how much change there is constantly … Uh, restructuring, um, merging with other trusts, as part of the whole central government initiative of getting the best price for each service …” (Sally, SE, talking about her time in the NHS)

“…it’s knowing you’ve got five new patients that have come in that week and they’re on your waiting list and there’s nobody to go and see them ‘cos everybody’s working flat-out.” (Kathryn, social enterprise)

“…and then you’re going back the next day and starting that all over again.” (Alice, ex-NHS)

Carol provided a vivid description of the workload specific to the role of an SLT employed in the NHS. Her account allows insight into how workload can be characterised by attempting to fit an essential, necessary number of tasks into pre-determined time slots.

“… community-based therapists could only have a 30-minute slot for children, and in that time they had to make sure they recapped on what they’d done before, they did this week’s therapy, they made sure the parents were totally understanding what they had to do this week in time for coming back the next week, and they had to get all materials and everything ready, type up their notes so that they were ready for the next patient, for ***their*** *30-minute slot. Honestly, honestly. You know, that’s how it, that’s how it was, that’s how it still is.” (Carol, ex-NHS, ex-SLT)*

Self-employed SLTs were not immune to a sense of relentless work; because they were only paid when they worked. Those who worked in schools (and therefore were only remunerated during term time) needed to ensure that they capitalised during term time to compensate for the periods when they weren’t earning. This resulted in unremitting demands for periods of the year, discussed by Ruby:

"I need to work probably at my maximum manageable for a lot of the term time in order, in some way, to offset the period of time where the, my income would be reduced by the, the school holidays." (Ruby, SE)

For SLTs in this study, their views of their workloads were not limited to the amount of work that they did, but also included the nature of that work. Pamela described the intensity of supporting and interacting with clients who have complex health needs. She used the term '*bombarded*' creating an image of a battle which was later reinforced as she discussed feeling '*defeated*'. Moreover, it was not always possible to plan for workload as an SLT could not always tell what the needs of a service-user might be, prior to working with them. Susan explained that service-users themselves might generate additional work. She described how it was difficult for her to refuse this, which is related to subtheme 1c; 'Feeling responsible'.

"I knew I was struggling because of the complexity of it, not necessarily my skills – it was just all-encompassing. I had hardly any time for anything else. Um, I'd be bombarded with, you know, information requests from dad and all sorts of stuff…I thought I was just going to go in and advise the staff… and just update the communication and just support them during this, you know, easy handover. Well, what a mistake that was [laughs]." (Pamela, NHS)

"…our job is more face-to-face, it's more kind of like clinical contact-based, like that is the kind of work that makes you take on extra things. Like, if you're sitting in a room with (a service-user) and they say, 'Oh, and could you write a letter for the social worker?' it's really hard to say, 'No.'" (Susan, NHS)

For Anne, the reality of her job was not aligned with information that the RCSLT publishes regarding the way that clinicians are working; she felt resigned to knowing she would not be able to complete her work. However, Jan's account demonstrated that she had adjusted to her workload – for her, the extra mile had become the standard distance. That said, Jan later commented that as a newly qualified SLT, her workload was protected to some extent.

"I have a lot of difficulties (with) the kind of mismatch between what we're fed in Bulletin, for example, and the whole reality of the job…I've got a 'to do' list way longer than I can actually get through…" (Anne, NHS)

> *"But now, because I've just got, I've just got used to that workload, and I just kind of know how to manage it. I know how to prioritise the things I have to do." (Jan, NHS)*

7.2.1 Marmite services: demand and capacity.

The perception that workloads were high, unremitting and intense appeared to be partly due to the capacity of services to meet the demand for speech and language therapy. Fourteen participants discussed their experiences that reflected demand and capacity. Hendre summed up these aspects of the job when she described her experience.

> *"I've always felt speech and language therapists are only little departments, aren't they? And if you're being spread out – I say to people, 'We're the Marmite service. We're spread so thinly...' (Hendre, NHS)*

Hendre's analogy of being 'spread so thinly' was echoed by others, with Sally questioning how to manage an expanding service with limited resources, and Gwenneth describing a negative impact on well-being. Strategies to manage capacity contributed to the pressure that SLTs experienced. Participants described their experiences and concerns around caseload sizes, targets and waiting lists/waiting times. For Gwenneth, these elements of the job contributed to the strain she experienced.

> *"…we've only got this much money, and we've got this ever-expanding caseload… Are we going to spread the jam ever more thinly?" (Sally, SE, discussing working in the NHS)*
>
> *"…you spread yourself too thin and then people feel disappointed that they're not able to do the best for everybody… I think there are other aspects of work that add to the stress. Like massive caseloads, waiting times, big waiting lists." (Gwenneth, NHS)*

For both Jo and Jan, caseload numbers were managed through setting targets to be achieved. Jan described how knowing there are targets to be reached became the backdrop to her working life as an SLT – even though she usually reached the targets, her awareness of those targets resulted in an underlying sense of anxiety for her.

“I think there’s external pressures from organizations and targets that are set by the government – things that we – absolutely have to be achieved [laughs]…you’re constantly having to re-prioritise, you know, can we see patients for communication today or not? Probably not. Not this week. It [exhales] really tight margins to meet…” (Jo, NHS)

“I think we, we also have like targets to meet in, in the community side of things, um, so we have to see so many patients a month. Um, which isn’t usually a problem, but that is always in the back of my mind, thinking, ‘Oh right, okay, I need to see more patients next week, because I’m not quite hitting my target.’ And things like that. So that kind of plays on my mind sometimes, makes me a little bit anxious, but I usually, usually hit it.” (Jan, NHS)

Hendre’s account provided further insight into the effect of targets on SLT well-being. The ever-present pressure she perceived to be present left her feeling anxious (‘…*it’s like a shadow…*’) and suffocated (‘…*there’s no breathing room*’). Target setting was beyond the control of individual NHS SLTs, a theme that will be discussed in the fourth theme; ‘Feeling conflicted, being in control’. Alice felt this lack of control, evident when she stated ‘*they then start on at you*’ – increasing her perception of the demands placed on her.

“…it’s like a shadow, scrutinizing how many patients you’ve see during that day. So it’s like a constant pressure. There’s no breathing room.” (Hendre, NHS)

“…it comes back to the pressures of they then start on at you at how many numbers you’ve seen.” (Alice, ex-NHS)

In some places, waiting lists were used as a strategy to avoid unmanageable caseloads. However, this did not necessarily lighten the psychological load of the SLTs. Anne and Gwenneth’s accounts demonstrated this. Anne explained that knowing how many children were on the waiting list was ‘*really difficult’* – during the interview her rate of speech increased when talking about waiting lists and she sounded upset, seeming to reflect her angst. For her, this knowledge formed the context of her working day. Gwenneth described waiting times – again, for her, being aware that children were waiting was a burden.

"I'm just finding it really difficult because I know that there are another 50 children on the waiting list, um, who, who are also all needing something." (Anne, NHS)

"…the waiting times do weigh on me." (Gwenneth, NHS)

Other participants viewed the issue of demand and capacity from a different angle – that of staffing. Jo's account demonstrated how poor staffing levels had a significant effect on SLT well-being – her use of the phrase '*on our knees*', alluded to the staff being exhausted. The experience of being severely understaffed also shaped the future behaviour of SLTs at work – they made decisions about what '*matters*' – although Jo did not elaborate on what it was that did not matter or how these decisions were made.

"Six months ago, we were really, really short-staffed… massive vacancies… we were all on our knees – so now we're just not doing things that don't matter." (Jo, NHS)

Pamela and Alice both recognised the mismatch between demand and capacity. Pamela's comment about '*huge*' demand and a small resource echoed the 'marmite service' analogy - for her this was central to her resulting stress. Alice's account provided insight into how concealing the problem through working extra hours perpetuated the pretence that the demand is met – this links to theme three, 'Feeling Validated and Supported'. It is arguably not helpful to mask a demand/capacity problem when attempting to demonstrate value to stakeholders.

"…we have a huge demand and a small resource – um – yeah, I think that's probably the crux of it." (Pamela, NHS)

"I think working extra hours above and beyond your contracted hours is expected, particularly at high levels. I don't think that's the right thing to do, I don't think you get any thanks for it, I think it masks a problem of not enough staff to deal with the caseload numbers." (Alice, ex-NHS)

There was also some evidence that participants felt unsupported by the RCSLT. Three participants mentioned this, with Anne's account alluding to disconnect between the RCSLT's apparent priorities and the realities of the job. Jo acknowledged the complexities around staffing but expressed her belief that the current attitude of '*just doing what you*

can' was not acceptable – that change should be fuelled by stronger protest. Jo's comments suggested a shift in responsibility for dealing with the situation – in this case from the professional body to the individual. Alice's account added to the possibility of a responsibility for managing capacity/demand being placed, not on the employer, but on individual SLTs.

"…the kind of mismatch between what we're fed in Bulletin, for example, and the whole reality of the job… Yeah, I think (the feeling of not doing enough is) coming more from things like Bulletin than from my department…we hear about 'research' but there's also the side of it where we're all just getting on [laughs] we're just…running around trying to find a tea set in a department that seems only to have half a tea set between thirty people…" (Anne, NHS)

"…you know in the Bulletin as well, and there's a, an attitude of, um, 'Oh, you know, we've just got to be positive and do what you can. Just do what you can.' And I find that so patronising. This is not good enough. We should be up in arms about it. And not accept appalling staffing levels... And I, yeah, I think there's a lot of denial around it, and, you know, and disconnect, really. Because it's, it's too massive to tackle." (Jo, NHS)

"I think, certainly where I was working, caseload numbers were going up year on year on year, but nobody was ever interested in looking at business cases to get more staff, it was always about, 'How can you condense things? How can you save money?'" (Alice, ex-NHS)

Trying to manage high caseloads could result in feelings of incompetency. Isabella felt her efforts were always deficient; and Anne felt inadequate because she was unable to complete the associated non-direct work that her caseload generated in the time allocated.

"I think, I think it can be a stressful job. I think in mainstream schools, uh, especially, the caseloads are really high and there are lots of government cut-backs so I feel like it's never enough, I feel like you're never doing enough, you're never meeting the needs of all the children." (Isabella, SE)

"And that makes me feel really inadequate, because I think, 'Well, why can't I do it in that time?'" (Anne, NHS, discussing report writing)

Self-employed SLTs were also vulnerable to stress associated with caseload size, but the underlying reasons for caseload pressures were different. Although they struggled with workloads, they demonstrated willingness to accept some responsibility for the amount of work they did because they potentially had control over their workloads. However, they did not always exercise this control. For Lesley, being unable to say 'no' resulted in a '*spiral effect*' – her mounting workload negatively affected her ability to spend time with her family. Ruby was willing to shoulder the added pressure that came with a larger caseload; the result of doing whatever she was capable of ('*whatever I can*'). Both Ruby and Lesley, who were self-employed, echoed Susan (an NHS employee, who described feeling unable to say 'no' in a previous extract), when discussing the tendency to over-commit. This over-commitment may be the result of the values and beliefs that SLTs held – ensuring that services were client-centred, feeling responsible for service-users, and being of service. The responsibility that these SLTs felt to service-users appeared to outweigh their need to take control of their workload.

"…my biggest problem, and I'm sure I'm not the first to say this, is I really struggle to say 'no' to people. I will get personal recommendations or referrals, parents will approach me and say, 'Um we've been given your number by another parent in the school, we would really like you to see our child.' I have, on occasion, tried to say, 'I'm fully booked, let's see if we can find somebody else,' and they would prefer to wait to see me, not to see somebody else which is quite pressurising because I don't really operate a waiting list so, so then I make a plan to fit them in. Which means I work longer hours, which means my family time suffers because then I'm racing around, and then I'm doing more work at home in the evenings. And that's when I kind of get into that spiral effect." (Lesley, SE)

"I have a number of schools that I work in and whilst I don't work directly for the school, I would always seek to try and support any families that came through that school, and even if that starts to put me under pressure, it's almost like my relationship with the school is that I will do whatever I can to support any children from your school." (Ruby, SE)

SLTs in this study, however, were not passive regarding the problem of staffing. Both Pamela and Jo's accounts demonstrated determination to have some control over the problem of staffing, by utilizing formal channels in an attempt to realise this. Both felt that the most effective way of achieving better staffing was to highlight risk.

“Our numbers (of SLTs) are ridiculously small, um, but that’s the place we’re in and we have to start from, to bring up numbers… there should be more, you know, National Guidelines for staffing… I actually put that in, so the Risk Register, which is our sort of best mechanism to flag up staffing levels.” (Jo, NHS)

“We are trying to fill this gap over and over and over again. I’ve just put in a safeguarding referral…” (Pamela, NHS)

To cope with their workloads, participants worked through their lunch hours, stayed late or took work home, demonstrating behaviours that could be referred to as ‘leaveism’ (Hesketh & Cooper, 2014). NHS employees described these strategies as accepted working practice.

“I was doing a lot of extra work at home, just to keep on top of things… if you’re in community – you drive round all day [laughs], you stop for 5 minutes to eat your dinner and then you carry on and, I think that’s all expected.” (Alice, ex-NHS)

“So, there’s quite an acceptance of working late or taking work home to prepare.” (Gwenneth, NHS)

“So, in the NHS, I think it’s accepted that everybody works through their lunch, everybody works overtime.” (Sally, SE)

Jan described how these behaviours were reinforced both through colleagues and managers, which led to them becoming the norm. In Jan’s case, a change in staff meant a positive shift in attitudes to hours worked. However, the example of not taking lunch that was set by management filtered down to staff, who then engaged in the same behaviour. It can become difficult to reverse that norm, as explained by Gwenneth who had to ‘nag’.

“I think generally, we, we did have a couple of people in the team before that would always be the last ones in the office but they’re not, they’re not here anymore. Um, and, yeah, they sort of used to set a bit of a trend, of like, it’s normal to be in office till six o’clock sort of thing, whereas yeah. That, that, that’s not really there anymore. Everyone’s usually,

everyone's gone by like five o'clock…I think that helps everyone to finish on time." (Jan, NHS)

"I mean my manager is supportive of that, she does say, you know, 'You should have a lunch break,' and everything, but I know for a fact that she doesn't [laughs]. So, it's like setting a good example, I guess. And I'm the same, because when we have students, or you know, new people to the team, I will always tell them to have a lunch break but then I don't myself." (Jan, NHS)

"There – there's quite a sort of norm about not taking lunch break, working through lunch: 'Oh I just work through lunch, I just work at my desk' and we don't do that in my team, but I really had to nag everybody when we first moved into the building that we're in – and I made a real thing about insisting that we – people – took a break. I even made a rule that people didn't eat their lunches in the office because our clerical assistant finishes at one so people were eating their lunch where she was working and, I just thought, 'These are really bad practices,' so I worked really hard to do that. So, the norm for us is taking lunch, but I know the norm in other areas is not…" (Gwenneth, NHS)

Participants demonstrated both an element of taking responsibility for ensuring that they had a break at work, and an awareness of the effect that not doing so had on their well-being. They also demonstrated agency by taking control of the situation and having a break. The way this control was used differed across participants. Susan made sure a break was part of her everyday work, whereas Jan had a lunch break when she needed it.

"I've stopped working through lunch, like, yes. Because like the pressure is so strong, like there's so many things to do, and, but I've just had to like work out that for me, like that doesn't work. That's terrible. Like, I need to have a break in the day." (Susan, NHS)

"I'm not very good at having lunch breaks [laughs] I am aware of that… I always, if I am feeling stressed as well I, I try and do things to help that like, you know, just giving a colleague a call, having a chat, or making sure I take a lunch break that day, if I'm feeling particularly stressed." (Jan, NHS)

Because working late became the norm for some, SLTs could feel they weren't justified in taking time off in lieu. Gwenneth described her experience of discovering that one of her team had been doing a significant amount of work at home and had not claimed time in lieu for doing so.

"I said, 'Why didn't you tell me about that? You should be getting time in lieu for that,' and she said, 'Oh I didn't feel I could justify it'…I felt so frustrated, I thought, 'Where's this idea come from, that this is normal, that you take work home, you work over?' And the good thing is, in my team, is most of the staff don't work over, because we don't have it as the norm…" (Gwenneth, NHS)

There was a difference in the way that employed and self-employed SLTs viewed working extra hours. Willow admitted that she experienced shame about the resentment she felt if she worked overtime in the NHS but stated that because the tasks she chose to do as a self-employed SLT were achievable, she was more willing to work extra hours. This experience was shared by Sally. Her phrase '*it's not that if I don't work overtime the world is going to explode*' sheds light on how being self-employed has removed some of the pressure she felt while in the NHS. Both alluded to having more control over their work, a topic that is further explored in theme four 'Feeling conflicted, being in control'.

"I'm ashamed to say it, because when I was in the NHS, I did do some (work over weekends) but I resented it. Whereas I do it now, willingly. I think, because I choose to do that. I'm not in a situation where somebody's saying, 'This is what you have to have achieved in, in a week.' It's unachievable so the only way I can achieve it is to do it at the weekend. So, even though I probably don't earn any more, so it's not financial, it's not, 'Oh, that's being paid for now.' Those things are not paid for. I do that for free. Um, but – yes, it doesn't bother me in the same way, I don't resent it at all." (Willow, SE)

"… maybe the difference is that when I (work overtime) in the independent – world – I, I'm actually able to finish the job, whereas in the NHS, even if I did everything possible, I couldn't ever get it done. It was an impossible target… when I work overtime it's because I know that I, you know, I just want to finish this report because I know then that will be done… it's not that, if I don't work overtime the whole world is going to explode [laughs] so there's, I think there's less pressure…" (Sally, SE)

7.3 Subtheme 2b: Emotional Demands and Consequences

Subtheme 2a described demand in the form of workload for the SLTs in this study, which resulted in stress and anxiety for participants. In addition to the amount of work being overwhelming, many of the participants in this study discussed the emotional demands of the job, which further affected their well-being.

Some provided examples of specific incidents they found emotionally difficult. Susan explained how emotionally charged events happened within an environment of unremitting workload demands. For her this meant there wasn't time to process her shock and recover from one interaction before needing to be emotionally available for the next. She found the experience she was describing to be extremely unpleasant – '*horrible*' – possibly because she could not help – she could not make a difference. When recounting this experience, Susan appeared to be distressed; there was tension in her voice and her facial expression signalled anguish. Both the psychological state of the service-user and Susan's inability to affect change (a core value for her) contributed to an emotionally loaded interaction. The effect of this was that she left work early, something that she '*never*' usually did, as it resulted in work being held over to another day. Susan's anger appeared to be linked to her having no control over service delivery constraints – a topic that will be discussed in superordinate theme four, 'Feeling conflicted, being in control'.

"And then, like, like a man phoned me up in tears because his son needs speech therapy and I had to (unintelligible) like, 'I don't know when your son will have speech therapy, I can't help you,' and, um, and it was ***horrible****, and then I had to go straight into a session and the session was, it wasn't bad, but it was really intense, it was really, like it was very, like a child that needs all of your attention and then [pauses] and then I can't remember what happened but I know it culminated, like with um, leaving work early, which like I never do…we're allowed to. We're allowed to be flexible with our time, if we're doing admin. But like, I* ***never*** *leave early because then there's more admin to do on a different day, um, but I* ***just*** *[pauses] it just makes me really [pauses] just like unbearably angry… it's something that – culturally, you don't expect a man to cry, like it's always a bit shocking when a man is crying. And he was crying a lot." (Susan, NHS)*

Others gave examples where they were required to support service-users and their families through particular experiences. For Carol, her role as an SLT included counselling families and she drew on her own experiences of stress to recognise stress in service-users, although this did not prevent her from feeling anxious during the experience. She described her anxiety as being on behalf of the service-user. She also mentioned the role that SLTs play in diagnosing disorders and how that role usually involves supporting families through the emotional journey of receiving a diagnosis. She felt that this had an impact on SLTs' stress levels. While Carol discussed stress and anxiety, Pamela described supporting families through traumatic health events as 'draining'. The accounts of both participants allude to the responsibility they felt for service-users with whom they worked.

"So, one of my roles for (the mother of three children on her caseload) was taking on a sort of counselling … I couldn't walk away from her, as a woman who was vulnerable. You know, a couple of times when she came to see me, she was sort of on the verge of tears, or I could see in her, the things that I'd experienced in terms of stress previously... I just became more and more anxious for her..." (Carol, ex-NHS, ex-SLT)

"…the stress level of actually making a diagnosis, sharing that information with the parents, you know, and supporting them through it all, and – as a profession, we recognise that that's something we do. We do an awful lot of." (Carol, ex-NHS, ex-SLT)

"… they were still kind of, I think, reeling from the trauma of (their son being critically ill) really, as a family… this, um, family, um, are draining you." (Pamela, NHS)

Alice described her sessions with patients who have motor neurone disease (MND) as '*heavy*', evoking a sense of burden. This had the effect of sapping her emotional resources and resulted in her feeling drained. For her, it also impacted on how many patients she felt able to see in a day, linking to subtheme 2a, and demonstrating how workload demand (the need to meet targets) and emotional demand are associated. Alice described how she was working in the way that she felt she '*should be'* – she did this despite the external pressure to see more patients. Her exhaustion not only stemmed from the emotional demands of her work, but from the resulting conflict between external expectations and her own belief in client-centred care. This conflict is further explored in superordinate theme four, 'Feeling conflicted, being in control.'

"…lots of MND patients, quite heavy, quite emotionally demanding sessions, could be with somebody for a couple of hours, feel, you know, quite drained at the end of it, but that's okay… They're getting upset, you're counselling them, you're dealing with their emotions, you can't do that in 20 minutes and then run out the door 'cos you're got to go and see somebody else. So, I think, and again, I think that is the way that we should be working. I think that's a really good thing to do but when you've then got the pressure of, 'Why've you only seen two people today? You've only seen five people this week. What are you doing? Why aren't, you aren't doing enough work, you're not seeing enough people.' I think that becomes exhausting." (Alice, ex-NHS)

The accounts of other participants provided further illumination regarding the consequences of an emotionally demanding job. Pamela, Gwenneth and Susan also mentioned fatigue in relation to the nature of the job, with Gwenneth describing the effort needed to compartmentalise her work and '*switch off'*. Susan expanded on how tiredness affected her efforts to look after her well-being. This exemplified how, despite Susan wishing to take responsibility for her own health, her work – which she was unable to control – had a negative effect on her ability to do so.

"…um, is tiredness an emotion? It's not really, is it? Weary. Oh, yeah, everything's an effort." (Pamela, NHS)

"…sometimes I just feel absolutely exhausted, worrying about other people's children… you spend so much energy, from the minute you get up in the morning – I was driving in to work this morning thinking about a boy that I was going to be seeing this morning, had all kinds of thoughts going through my head and it's absolutely exhausting. So, when I get home from work, I do try really hard to switch off." (Gwenneth, NHS)

"So physically, like, I get really tired. Like really tired. And then, and then it can spiral quite quickly actually, because that's when I stop doing all my well-being planning and I don't cook a healthy meal, and I don't do my exercise and then, and I know it's going to make me feel worse, but I just feel exhausted at the end of the workday." (Susan, NHS)

In addition to anxiety, stress and fatigue, SLTs reported feeling distressed when working with people who have experienced severely traumatic events.

"I mean, some of the cases that I saw… as an example, one woman had been set fire to. I mean, just so distressing." (Willow, SE)

"I once had an extremely distressing case – em – involving a young person who'd just been abused in the most horrendous ways…" (Gwenneth, NHS)

SLTs in this study, in addition to working with people who were upset or worried, also interacted with and supported service-users, relatives or carers who were angry and possibly abusive, as described by both Gwenneth and Kathryn.

"…the dad happened to phone the next day and he was really angry…he was really, really worked up as some people are, and quite loud and vocal and I remember him saying to me, 'I think you've forgotten about my son.'" (Gwenneth, NHS)

"And I know people get abusive and aggressive in hospitals 'cos we hear about that all the time. What you don't hear about is some of the abuse and aggression you get in the community…people are angry. They expect you to sort things out, there's that culture I think now, a bit in this country, where 'I pay my taxes, I pay your wages, you're a public servant, you will sort this out.'" (Kathryn, social enterprise)

Hendre provided a contrast to the participants already described in this subtheme. The accounts so far have focussed on emotional strain that resulted from interactions with service-users, their families and carers. For Hendre however, the emotional strain of the job also resulted from relationships with colleagues – in her case, with a manager who was unsupportive and '*seemed to target'* her. She felt '*bullied*' and stated that she and her colleagues spent a lot of time discussing the difficulties they were experiencing with their manager; the term '*spew it all out'* evokes a rapid and forceful purging of feelings. Her account also demonstrated how SLTs needed to have the emotional resources to support service-users, while dealing with work relationships. For Hendre, the combined burden of a difficult work relationship and the emotional demands of her job, without adequate support, culminated in her taking six months sick leave.

“We talked about (management difficulties) every single day”. (Hendre, NHS)

“Um, (supervision sessions) definitely helped because you’d sort of have that chance to spew it all out, before you had to go in to, you know, see patients who had their own problems, who needed you. You know it’s [trails off]” (Hendre, NHS)

Pamela went beyond describing the emotional consequences of working with people. She provided an arresting account of the emotional and psychological impact that working as an NHS SLT has had on her. This impact culminated in her need to take prolonged sick leave. She described how the culture within the NHS encouraged people to work hard, ‘*sometimes too hard’*. Her account contained contradictions – she said that the NHS ‘*beats you hard’* but ‘*looks after you’* and that she was ‘*grateful to the NHS.*’ Explaining that she had time off work for stress, she added a family member’s opinion that the NHS ‘*won’t be pleased*’ but countered this with her view that the NHS itself was ‘*partly to blame’* for her being off. The word ‘*partly*’ indicates that she felt she should carry some of the responsibility for her stress – Pamela had earlier spoken about fears that she was not capable, and that she had ‘*imposter syndrome’*. Her emotional reaction to her work and her employer was ambivalent and stating that the NHS ‘*beats you hard*’ and that she was ‘*grateful to the NHS’* and ‘*very lucky’* is disturbingly reminiscent of the language used by people in abusive relationships.

“Um, so, um, but I’ve been very lucky. The NHS – it beats you hard, to work hard, it makes you work hard, um, and sometimes too hard – you know, they, I think it’s the culture and the nature of the organisation – um, maybe the type of work we’re doing - to put other people first, but it also looks after you to a certain degree. Well, it has me. I’ve had very good experiences of being looked after… And that’s where I feel – sighs [tearful] – you said it would get emotional, grateful to the NHS because it’s an employment where you can take sick leave and you can recover. But, as my father-in-law said, when I’d been off for four months, ‘How long have you been off for now?’… Um, I said, ‘Four months,’ and he said, ‘Oh, well the NHS won’t be very pleased with you, will they?’ and I found myself saying, ‘Well, they’re partly to blame for the reason I’m off’ [laughs].” (Pamela, NHS)

In this study, SLTs working independently were not impervious to the emotional consequences of providing emotional support as part of their roles at work. Like Pamela, Isabella used the word ‘*draining*’, evoking a sense of exhaustion. Her statement that

working in a job that isn't people-oriented might be '*quite a relief'* speaks to the release she would feel should she end her current anxiety-evoking work. Furthermore, she mentioned '*switching off'*, once more echoing those who are employees.

> *"…with the vulnerable children and adults that we work with, I think there can be stress there, and it's draining, and I think that it's a job that sometimes you take home with you. So, I think it's similar in independent work and the NHS… But sometimes I just think, 'Yeah, it would be nice to have a job where it's not so people-oriented.' Just go into work – boom – come back, switch off… What would that be like? It might be quite a relief." (Isabella, SE)*

Ruby described the combined pressures of facilitating change while working with families who are potentially '*quite needy of you*.' If viewed neutrally, the word 'needy' might imply only the requirement for some sort of support, however, the word has negative connotations, hinting at fragility and the need for a high level of reassurance. In addition, there were interactions with other professionals that might require her to respond to the feelings of her colleagues. Her statement that there is '*probably*' a large emotional and mental weighting to the job suggests that clinical matters, and not the emotional or mental requirements of the job, are the usual focus when discussing SLTs' work. However, she did state that the emotional component of the job – both in terms of what clients need and the effect that has on SLTs – are an accepted part of the role.

> *"…it's not always smooth, easy interactions… So I think obviously you've got the pressures around delivering positive outcomes for people, um, you've got all of the pressures around the interactions that you're having with families and children, who are, potentially might be quite needy of you – in terms of what you're providing and the reassurances that you're providing. There's actually all of the potentially quite – um – sensitive liaisons with other people such as teaching staff, maybe NHS speech and language therapists who are in the mix and all sorts of things. So you've got all of those things, which are, clinical issues – largely. Although there's a, probably quite a large emotional and mental weighting to it… it's accepted that that's, you know, you have clients who are having difficult experiences and that that bounces back to you in any way, shape or form, that you are there to absorb it, um and that would be just kind of part of the role." (Ruby, SE)*

Ruby's comments resonated with the experience of the SLTs who were organizationally employed. There was conflicting opinion on whether the emotional demands of the job were well-recognised within the profession. Susan's statement implied that this was the case, but Jan felt that there needed to be more acceptance of the emotional repercussions of working with patients who are '*really poorly'*. Her words, '*hit us quite hard'* provided a sense of the degree to which SLTs may be affected by their work. In contrast to Susan, Jan felt that the emotional impact of the work that SLTs did needed to be better accepted and acknowledged within the profession. She returned to this thought numerous times during the interview. For Pamela, who worked with adults with learning difficulties, decisions she made about the intervention provided could be life-changing for service-users, echoing concepts identified when examining the concept of responsibility in the first theme, 'Being an SLT'. Despite this, she felt that these '*emotional decisions'* were not recognised.

"So I guess, like everyone I know has kind of accepted there's a level of stress that comes with working with people in an emotional way." (Susan, NHS)

"…obviously we see people go through really tough times and really difficult things…I think sometimes we take for granted, like the, the, patients that we see that are maybe really poorly, that might hit us quite hard?" (Jan, NHS)

"Like emotionally…I think it's just making it more accepted that that might affect you and that, you know, I don't know… making it more of a thing." (Jan, NHS)

"Nobody says, you know, you have to make that decision and it's such an emotional decision. Because, you have to be aware that this is somebody's life that you're affecting, you know – big time – their well-being." (Pamela, NHS)

The perception of some that the emotional element of their job was sometimes not recognised or supported, despite the level of responsibility that their decisions sometimes carried, links to the next superordinate theme – 'Feeling validated and supported'.

7.4 Subtheme 2c: Ensuring a Service was Income-generating

There was a contrast between the employed and self-employed participants regarding the role that remuneration played in well-being. For the self-employed participants, ensuring their services were income-generating was a demand that contributed to their stress, whereas this was not mentioned by the SLTs who were employed. The nature of self-employment for the SLTs in this study meant that income could be inconsistent – despite this, participants needed to ensure that their income met their regular financial commitments. Lesley stated the case simply.

“It is critical that I’m earning money.” (Lesley, SE)

Isabella’s account sheds light on the reality of coping when an income is inconsistent. Her knowledge of not having a regular salary was always present, it was a burden for her and resulted in her feeling that she was unable to take time off when unwell – she felt she had to continue working against the advice of her GP. Isabella also alluded to an underlying feeling that not coping was shameful, her distress embarrassed her.

“I had to borrow from my mum at Christmas time. [laughs]… it was a bit of a wake-up call, hmm, the safety-net is a lot less. If I fall off my bike, yeah. [laughs]…It’s there. It weighs on you a little bit… And friends of mine in the NHS who have been feeling really unwell, in terms of their well-being, and, you know, their doctors have signed them off. The doctor offered to do that for me, and I was like, ‘I can’t afford it. I’m self-employed. I’m just going to have to keep on trucking.’ She kind of looked at me, and she was like, ‘You’re crying here in my office.’ I was like, ‘I know, I’m embarrassed. I don’t mean to.’” (Isabella, SE)

Finally, for Ruby, there was a realization that an additional layer of pressure resulted from having to ensure her financial security – anxiety resulted from the tension between providing a quality service and ensuring regular income.

“…there’s a different caseload pressure for me – because nobody is externally, um, stating that I have to do X amount, but I have the, the kind of business pressure of actually making sure that I’m actually, um, you know, financially viable... there’s actually the whole, another level of stress or pressure which wasn’t present when I was an NHS therapist – which is actually about making my living. And actually being able to manage a caseload in such a

way that it's a balance between clinical quality and actually providing a, you know, a viable income as well." (Ruby, SE)

7.5 Summary

The accounts of participants in this study revealed that their daily working lives presented a number of challenges. Because the capacity within services did not always meet the demand for speech and language therapy, SLTs could find their workloads overwhelming and stressful. Staffing levels, targets, sizeable caseloads, and large waiting lists/long waiting times all contributed to SLTs feeling exhausted, incompetent and inadequate. Self-employed SLTs were not immune to feeling overwhelmed, due to feelings of responsibility to, for example, the schools in which they worked. An additional demand for those who were self-employed was the need to ensure their services were sufficiently income-generating. The compassion and commitment that participants felt towards service-users could result in them worrying about patients/clients. Meeting the emotional needs of clients could lead to stress, fatigue and feelings of anxiety. However, there was conflicting opinion about whether the emotional demands of the job are recognised within the profession. The 'Marmite Service' analogy captured the essence of the experience of participants in this study – their perception of their jobs was that they spent more time, personal resources or energy than could be maintained or sustained.

CHAPTER EIGHT: SUPERORDINATE THEME THREE
A LACK OF VALIDATION, FEELING UNSUPPORTED

8.1 Overview of Superordinate Theme Three

This super-ordinate theme describes how participants felt they were viewed by others, the effect this had on them, as well as the support they received. The four subthemes identified reveal that the profession was not well understood, that some SLTs did not feel valued for the work they did, and that this could mean their experiences of working included attempts to justify their roles and their existence, and efforts to prove themselves. Finally, the support that participants received as part of their role – both formally and informally – is discussed. All the participants contributed to this overarching theme. Similarities and differences across the employed and self-employed groups is discussed.

Superordinate Theme Three	Subthemes
Theme Three: A lack of validation, Feeling unsupported	3a: The profession is not understood 3b: SLTs don't feel valued 3c: The need to justify the profession, and one's own existence 3d: Support – formal supervision and informal support

8.2 Subtheme 3a: The Profession is Not Understood

Most of the participants' accounts included experiences of their role not being understood by others. Some, such as Jan, spoke of this in general terms. Her statement about being able to make an '*impact*' also links back to subtheme 1b, where affecting change was discussed.

> *"I feel like a lot of the time people don't know what we do? Which can be a bit frustrating… that a lot of people don't realise the impact we can potentially have." (Jan, NHS)*

Despite feeling that the profession was not understood, when asked whether the other members of the MDT in which she worked understood her role, Jan felt they did. Jo, however, provided a striking example of the profession not being understood by the wider hospital staff when she described the difficulties that result from coping with high numbers

of patients, and with dysphagia assessment being prioritised over working with communication difficulties.

"…it's sheer sort of numbers…there's not the recognition of the unique skills speech therapists have…It's a sort of downward spiral, um, because then we've got such a low profile in the hospital, people don't understand what we do, and of course we've got the dual role (supporting swallowing and communication difficulties), um, and they don't know what they're missing. Um, so, you know, there's this sort of cliché about, oh SALT (speech and language therapy) assessment – you're referred someone a swallow assessment – I think a lot of staff don't even know we do communication. And I had an email the other day, um, about MDT training and I nearly fell off my chair. It said, under the heading 'communication': OT Assessment of communication, cognition and something, something. Um, support – how to support patients with communication impairment to engage. So obviously I sent a reply clarifying we would be leading on that topic." (Jo, NHS)

This lack of understanding was frequently explained by describing the expectations of non-SLT managers regarding output i.e., the number of patients or service-users seen in a day, with SLTs being compared inappropriately to other professions such as nurses. Hendre explained how service managers in her locality had poor comprehension of how SLTs worked. For her, this included a failure to appreciate the differences between SLTs who had different roles, i.e., inpatient versus community services. This then influenced how targets were set by managers.

"Because the other thing that I feel is that there are managers looking at (numbers of patient contacts), who don't necessarily understand what a speech and language therapist does and compare what is not comparable. So, if you have someone maybe working on a ward, they will be seeing a number of patients, because they're just sitting in the bed on the ward. There's no travelling between, but if you see someone at an outpatient clinic or you're doing domiciliary, then obviously there's huge changes in people's distances and timetables. But it's like, 'Well, they're seeing so many patients,' and it's about quantity and not quality." (Hendre, NHS)

"…we had a mock CQC inspection once and a manager from another team came out and was really quite shocked that I'd only see a couple of patients in a morning and couldn't understand why it was going to take me an hour to look at all this data and write it all up, and was saying, 'Well, nurses see 20 people in a day." (Jo, NHS)

When recounting her time in the NHS, Sally felt that a lack of understanding by senior (non-SLT) managers meant two things: Firstly, the restructuring of the service in which she worked did not reflect the way the profession is structured. Secondly, tasks were not appropriately allocated. The 'managerial decisions' to which she referred are the processes in which service-users were allocated to specific treatment pathways. For Sally, the employer's lack of understanding of the value that qualified SLTs added to a service was evident in recruitment policy which was financially driven ('*they're cheaper*').

"…the powers-that-be that decided on this, like pyramid structure that they wanted to enforce, didn't really understand the nature of speech and language therapy as a profession." (Sally, SE)

"…some of our managerial decisions were actually being made by a speech and language therapy assistant. Because it was deemed to be 'administrative' work… I know it sounds crazy, but, um, very often they would replace therapists with administrators… Or, for instance, my day was replaced by a speech and language therapist assistant. Because they're cheaper". (Sally, SE)

This lack of consciousness regarding what speech and language therapy is was not limited to decision-makers. Gwenneth described this lack of understanding in relation to working with teachers and other education professionals (the 'referrers').

"…what I find hard is trying to make enough time to have good communication with the referrers to help them understand our role and feel confident in us…" (Gwenneth, NHS)

Not feeling understood could result in demoralization, as described by Carol. She referred to being demoralized twice in this extract, and again in a later comment, indicating her strength of feeling. Her comment about '*getting lost somehow'* alluded to a situation that led to senior managers being unaware of the existence of SLT services. Trust policies could then result in objectives and targets being irrelevant for SLT services.

"We were in the MSK (musculoskeletal) and Frailty Care Group because we were lumped in with the physios and obviously that's the best place for them to fit – so speech and language therapy in an acute trust, I think, can get lost somehow, so there's all that sort of demoralization in as much as, … well, we're not recognised. None of the policies, none of these, bits of work that we're doing, none of these targets relate to us at all. And you just think, 'Well, what am I doing?' You know, that's not important so I want to focus on the children but actually, I can't do that either. You know, so those feelings of not being able to do what you wanted. It is demoralizing, isn't it? But you're still trying to do your best." (Carol, ex-NHS, ex-SLT)

Pamela's account further expands the point of NHS targets that were irrelevant for SLT services. She raised how the RCSLT, and the profession generally, sometimes agreed with (are *'signed up to'*) wider hospital decisions that influenced service delivery. She questioned this compliance, stating that, for example, broader NHS treatment pathways could be irrelevant for SLT service-users. Implicit in her comments is the feeling that the professional body should not comply with broader NHS decisions, if they are inappropriate for SLT services. This compliance is important when considering how the profession is understood. The failure to question decisions is arguably not constructive in furthering understanding of the profession, as potential opportunities for educating wider health professionals may be missed. Pamela's referral to service-users again demonstrates the emphasis SLTs placed on client-centred care.

"…we've kind of signed up to it. The, the Royal College has signed up to it. Um, and I'm not sure, I don't know if that helps us… You know, why have we signed up to this referral to treatment pathway that hospitals were signed up to? It's irrelevant for our service-users." (Pamela, NHS)

None of the self-employed SLTs in this study mentioned feeling misunderstood by their clients, other professionals, or the public in their present roles. The only time the topic was raised, was in recounting experiences they had had in the NHS. It could be that because their services were directly commissioned by specific organizations (e.g., schools) or by individual people/families needing support, those purchasers understood what they were paying for. It could also be that, because self-employed SLTs are in effect their own service managers, they had the ability to ensure ongoing understanding through directly working with their clients, or commissioners.

8.3 Subtheme 3b: SLTs Don't Feel Valued

All 15 participants discussed how they did not feel valued and/or provided examples of occurrences that had left them feeling undervalued. For Hendre, a lack of understanding, coupled with managers' needs to meet targets left her feeling exasperated, unappreciated, and frustrated. For her, there was no acknowledgement of the complexity of the job involved.

Hendre: Um, the area manager for us stood in front of us all on a day that they'd organized for team building, and said, 'Do you know which is the best-performing service?' Everybody was sort of… [trails off] 'You are'. And we all went [makes a confused expression]. But it was because we were taking people off the waiting list at 8 or 9 weeks and other services were taking them off at 13 to 14 weeks. So, we were deemed to be the best-performing service. Well, you know, we were saying, 'That's just taking some names of the list, that's not doing anything to them. We might have sat there with them, had a cup of tea, and said, 'Oh, terribly sorry you've got Parkinson's disease, anyway, see you again.' And walk off. So, there was nothing about what we were actually doing with those people – it was that we were 'taking them off the list' [said with a sing-song intonation]. And that made them look like excellent managers.

Claire: But it made you…

Hendre: SO frustrated. Undervalued. You know, we were just workhorses, to make them look good. And, um, you know, 'Where's the patient in all of this? Where's the patient's voice in all of this?' was what was really difficult for us.

Hendre's use of the word '*workhorses*' may be interpreted as feeling like she was being treated as a labourer – with a focus on expediency rather than being client-centred, and thus violating one of the values identified by participants in the first theme.

For Susan, feeling undervalued stemmed from being asked to do tasks that she felt were not aligned to the specific skills that she had as an SLT. Furthermore, Susan felt that her employer demonstrated this absence of appreciation for the job she did through failing to

effectively link the tasks that she was being required to do with the remuneration she received – she felt that she was effectively overpaid for doing administrative work.

"…(I feel that) somebody could do (diary management) on an admin grade and it would be their job and they could probably do it right, and it would cost a lot less for the NHS. So then I feel, like I feel really undervalued because of it, I feel like, yeah, my workplace hasn't, like cares enough about my job to pay me to do my job for the whole time I'm at work? Um, which is not a nice feeling, I would rather feel much more valued…" (Susan, NHS)

Susan's feelings about being valued however, were not consistent across different levels. While she felt that her job was not valued by senior decision makers, she did feel valued by her immediate SLT colleagues.

"I feel really valued, like in the team that I'm in, I feel really valued…it's about recognition…I feel supported." (Susan, NHS)

Kathryn described having attended a course about humanization in healthcare, and the thoughts that doing so engendered in her. She first stated her feelings about the importance of being more humane in healthcare, a concept that links to client-centred care. Mentioning this first enabled her to signal that her first priority is her patients. She then expanded, explaining how it is important that staff are humanized. Kathryn's account shows her experience to be one of not being treated like a human being. This appears to be as a result of being expected to 'automatically' meet targets. On three other occasions during the interview Kathryn mentioned the pressure of having to meet targets – this was clearly a concern for her.

"…I thought that was really interesting and I think that's something that is often missed – being more humane with patients – and I think that's really important. But it's the humanization of staff as well and I think that's important – treating your staff like they are human beings and not just there to get – automatically get – people through a job and meet targets." (Kathryn, social enterprise)

Those who were currently self-employed frequently referred back to their time as employees, reflecting on how they felt under-valued in their previous jobs. This was evident in Ruby's account, when talking about her time in the NHS. Her description of working with teachers left her feeling frustrated.

> *"I think that when I was, um, working in the NHS, I think I was frequently frustrated by feeling that, um, I, my advice wasn't being taken account of, or seriously, or I would make recommendations and people were unable or unwilling, to follow them or just didn't value them, and I think I frequently felt frustrated." (Ruby, SE)*

Not feeling valued, however, was not limited to those SLTs who were organisationally employed, with some self-employed SLTs describing similar experiences. Lesley's account included experiences of not feeling valued by other professionals, expressed in a general sense when talking about teachers. Lesley also linked this to the level of control that she has. Control will be discussed in more detail in the next superordinate theme.

> *"I think for me, one of the biggest frustrations is not being heard, or not being valued…I'll be working with a child where there would be, um, advice that I offer to the teacher that doesn't necessarily mean she has to put in any extra work, it would just be perhaps, applying some strategies, or when she's doing reading with the child to try one or two things – and I feel that there's a resistance. Um, I don't have the authority or the control to enforce that, um, and it can be quite difficult…" (Lesley, SE)*

Lesley also related a specific experience where a manager (a Head Teacher in a school) did not value her. She described a meeting that she attended where parents and school staff were present, and the effect that the experience had on her. Her use of the terms '*violated*' and '*used*' are suggestive of an invasion of her professional being, where she was manipulated for somebody else's purpose; and resulted in strong anger (illustrated by her repetition of the words '*very*' and '*angry*') and a loss of trust between Lesley and her client.

> *"I felt violated in that meeting, because (the Head Teacher) had completely manipulated what I said… I came away from that meeting very, very angry. Angry. I felt that my relationship with that, that Headmaster had kind of been destroyed… after the meeting the mother approached me and said, 'Did you know about it? Were you part of all of this?' and*

I felt that that had really broken down [trails off]. The, the parents lost trust in me so then I had to – I came away and I, yeah, I was just like, 'Oh my God, this is just horrendous.' But then I had to, so I had to rebuild the trust with the parents…I was ready to pull out of that school. I was ready to go, 'You know what, I can't work like this. I don't feel respected, I don't feel valued'. I felt used. And I was ready to, to pull out of the school." (Lesley, SE)

Isabella's account revealed how, in addition to areas such as management decisions, and interactions with other professionals, expressions of gratitude might contribute to feeling valued.

"So, no-one says 'thank you' a lot of the time… A little 'thank you' goes a long way, sometimes. 'Cos you know you're working really hard and you're doing a really good job, and the schools know you are too. And even the SENCOs that really appreciate, they often just don't say 'thank you'. And I know they mean it, I don't know why, I've just always thought, a simple 'thank you' sometimes [laughs] would carry me over for a term." (Isabella, SE)

Some participants discussed NHS banding, and feeling undervalued as a result of having been regraded to lower bands during service restructuring, or a failure to progress up the banding scale. Their accounts revealed that SLTs derived a sense of value through financial reward. Sally and Susan both mentioned salary implications around banding. Sally reflected on her time in the NHS when her sense of being demoted as a result of re-banding left her feeling undervalued. Sally's use of the phrase '*squish me down'* evoked an impression of being suppressed, of the discomfort that she felt in needing to occupy a new, and 'lesser' space within the professional hierarchy.

"I was paid at a specialist therapist rate, even though five years before I had been on highly specialist, but they deemed it to be not too bad to squish me down. So we'd been, we'd been – demoted I suppose? [laughs]" (Sally, SE)

Susan discussed the financial impact of inappropriate banding. She described the work that she did and how that did not match the band she was on. For her, being on a lower band than she felt she should be meant she was not being recognised or valued for the work she did. Furthermore, Susan's inappropriate banding had a significant financial effect for her – she would need to make a choice that would have a substantial impact on her

life: to move away from family (which she did not want to do) or be unable to buy a home (which she would like to do).

“I would like, like, to mainly develop my job description to match the job that I do, and then almost secondary, but also important, is actually be paid more… it’s the recognition that feels important. But actually, like in my life, in terms of living in (this area), and, like needing to have a mortgage, to live somewhere (in this city)– so at the moment I’m renting, I’m renting in a shared house and it’s, like I really love it, but it’s not for the long term. But like on my salary now I have to move out of (this city), where my family is, or I have to stay in rented and I really perceive that if I was just one pay grade higher, that that would make the difference for me. That is the thing that would make the difference. Which has quite a big impact, for something that is not even ***right****. That’s a big impact for it to have.” (Susan, NHS)*

Two SLTs who had left the NHS discussed the financial implication of being downgraded. Because being downgraded left Carol with less disposable income, she was required to make savings. She changed her working practises to save money on petrol – she negotiated to work her fulltime hours over four days. This resulted in long hours that had a negative effect on her well-being, which she did not recognise – *“I really did not recognise the impact.”* The change to her working life contributed to her reaching a point where she needed time off for stress, and she ultimately left her job, and the profession. Alice’s sense of her own value came partly from being told directly by a manager that she probably hadn’t ‘*deserved*’ to be paid at the grade that she’d previously occupied. Her line manager neither understood nor valued what she did. For her, feeling valued included being able to use her skills and be appropriately rewarded – through remuneration – for doing so. When she received her first payslip after having been downgraded, this combined with other stressors that she was experiencing at the time meant that she resigned – *“…that was the trigger.”* She left the NHS in the hope of regaining her sense of value. Although Carol and Alice resigned for different reasons, having been downgraded contributed to the decision in both cases.

“I’d gone through my third consultation for restructuring, reorganisation, had lost my Band 8A post that I’d had for thirteen years. Um, with a really horrible outcome, having been told by a senior manager that I should think myself lucky I’d been paid at that level for that long because I probably didn’t deserve it anyway…what my husband said to me on many occasions is that I’ve outgrown the NHS because the NHS is not prepared to pay me for what I’m able to do for it. Therefore, to step outside the NHS and to work privately, to be able to use my skills properly and to earn my money that way, is, is the way forward, for me.” (Alice, ex-NHS)

As a self-employed SLT, Isabella also acknowledged the role of remuneration in feeling valued. She described how some self-employed SLTs charged low rates, and how she felt this undervalued the service provided. Her comment ‘*we undervalue ourselves’* recognised that self-employed SLTs must also assume some responsibility for the profession being undervalued.

“I know very, very experienced, amazing speech therapists who, um, you know, private therapists, who charge…quite a low rate. And that’s fine, that’s none of my business but I sometimes think we undervalue ourselves. So, no. Not because you want to make money but charge more because you’re worth more. And value what we actually do.” (Isabella, SE)

However, even when aware that undercharging would have a negative impact on how the profession is valued, some self-employed SLTs did not necessarily charge appropriately for their services. This links back to the belief that people should be able to access healthcare regardless of their financial position, and will be further discussed in the theme, ‘Feeling conflicted, being in control’.

“I struggle with the whole invoicing of people, um, I am – I never charge people for the full amount of time. I always give people more time – objectively people have told me I’m undervaluing myself, it’s the wrong thing to do, I’m undervaluing the profession. I am aware of this. Totally aware of it, but I really struggle.” (Lesley, SE)

Some participants felt that the profession not being valued was inevitable. One reason given for this was that speech and language therapy was a relatively small profession, further diminished by staffing cuts, as discussed in subtheme 2a, ‘Daily working life - too

much to do'. When service capacity could not meet demand, this played a crucial role in the ongoing struggle that SLTs faced when attempting to demonstrate the impact that they had, and therefore justify their role, influencing how they were valued. For Jo, it was '*obvious to everyone'* that the service was '*pretty shit'*, a situation unlikely to result in the service being valued. Hendre's use of the term '*popping in'* implied a brief, or casual visit, suggesting that the role of SLTs would not be considered seriously.

"(The service) has the reputation it deserves, you know, that the speech therapy service is pretty shit. It's obvious to everyone. Because it has a history of being depleted." (Jo, NHS)

"There's never enough of us about. And it's like a catch-22 then, how do you show your value when you can't actually do that job well? So how do we make an impact, how do we show our colleagues and stakeholders that we have a specific role to play with particular clients, if we're only popping in once or twice a week and we're not actually embedded within the team?" (Hendre, NHS)

Willow's account provided further illumination. She felt that commissioners not valuing the service was a logical consequence of her inability to provide an effective service when she worked in the NHS. This inability stemmed from being unable to offer patients the time that they needed due to service constraints.

"So, some of the evidence-based practice I couldn't put into practice because I could only see people three times… I also felt a lot of the time we were doing our profession a massive disservice. Because anybody who goes in, looking at what we were providing, you go in, it's not going to be effective, I can tell you ***now*** *it's not effective – so I'm being forced to work in a way that I know is not effective. So, as a commissioner, quite rightly, coming in, they go, 'Well, you're providing this, but it's not effective.' And I'd have to go, 'Yeah, I know.' 'Well, we don't need speech therapy then.' They've got a point. [laughs]" (Willow, SE)*

Sally's account echoed Willow's, in that she felt unable to affect change, which resulted in other professionals not valuing her input. It also demonstrated once more how themes are interconnected. It has already been discussed how affecting change was important to the SLTs in this study. Sally had little control over her caseload size, meaning little time to prepare for sessions, which resulted in being ineffective. In the next theme 'Feeling

conflicted, being in control', it will be seen how a lack of control over how services are delivered meant that SLTs were not able to do their jobs 'as well as they could', which resulted in conflict for the SLT.

"…then the teacher, more often than not, would do what the specialist teacher advised, because nothing that you advised ever worked, and the reason why nothing worked, was because you only opened the child's file for the first time two minutes before you walked in and saw them. So actually, you didn't have the right equipment with you. And actually, this, that and the other. So actually, you weren't able to do your job as well as you could." (Sally, SE)

Others felt that SLTs lacked representation at levels where service decisions were made, meaning that understanding could not be furthered, and the role and value of SLT could not be argued for where it mattered. Jo made reference to the profession being female-dominated and appeared to link this to being under-represented at senior levels. She also felt that the 'profession' itself bore some responsibility for the way it was viewed by other health care professionals because senior leaders did not advocate strongly enough ('*missed opportunities'*) at broader forums. Her comment about being '*a bit too fluffy as a profession'* implies that the profession lacked seriousness.

"Um, I think, you know, as a profession, being female-dominated, and we've not had representation high enough in the profession. We've missed opportunities to make our case, um, you know, amongst the Allied Health Professionals. Our numbers are ridiculously small…I think we're still a bit too fluffy as a profession." (Jo, NHS)

Participants described a mixture of negative feelings resulting from not feeling valued. Recounting working in the NHS, Willow described disappointment, embarrassment, and how her feelings of worth were not constrained to being at work but spilled over into her life generally.

"That makes me feel disappointed, it makes me feel, um, that my professional opinion is completely eroded, it counts for nothing… I suppose I felt an erosion of my skills. Most definitely, um, I felt like I was letting patients down, um, I felt embarrassed. And like, for example, if these people were then going to another service, and they'd go, 'Is that what they've done?' [incredulous, disdainful] Um, so, you know, embarrassed, yeah. Um, what

else? Yeah, just, not good. Not good for your well-being…And it makes you feel, yeah, worthless, and, and, and those things carry over into your personal life". (Willow, SE)

8.4 Subtheme 3c: The Need to Justify the Profession, and One's Own Existence

Feeling that SLTs are neither understood nor valued resulted in participants feeling that they needed to repeatedly justify the profession, and ultimately the existence of their own selves. This process was sometimes a struggle and when unsuccessful could result in feeling disheartened, defeated and resigned to the situation.

Alice's account in particular described needing to justify herself, and her feelings of value and worth. When interviewed, she had very recently left the NHS. She described changes to the NHS service in which she had worked, which meant that her job was re-graded to a lower band – these changes ultimately contributed to her decision to leave. Alice relied on feedback from service-users for her feelings of worth. She repeated the words, '*your existence'* twice, a testament to her feelings of being valued as all-encompassing, going beyond a professional sense of feeling appreciated for specific tasks/roles and contributing to her sense of being. Her repetition of the words '*devalued*', '*justify*' and '*worth*' illustrate how important these concepts were to Alice, and the phrase '*grinds away at you*' implies her personal resources being eroded over time.

"And that constant having to justify quality over quantity I think becomes exhausting. I think that grinds away at you…So, again, you're constantly justifying your existence, justifying your worth, um, trying to prove that you're worthy of, of being in the job that you're in, really." (Alice, ex-NHS)

"I think (being downgraded) completely devalues you. Completely devalues you. And I think you can, you can deal with it for a while because, well, certainly in my case, I could deal with it because it wasn't about what other people thought. For me it was about the patients having a good service, and the patients getting what they needed. And I was getting that feedback from the patients and that was enough for me, that proves your worth, that proves your existence." (Alice, ex-NHS)

Others also discussed justifying their existence, as can be seen in Kathryn's account. Kathryn's use of the term '*battle*' suggests a struggle that is sustained and hostile.

Confrontation, stemming from a lack of understanding, was also apparent in Jo and Sally's accounts. They too employed the language of conflict, ('*fight*'), in their descriptions of arguing for the profession.

"And I felt like a lot of the time, throughout my career, I've had to justify what I do and justify my existence and I think that's getting better because we've got a lot more evidence out there about speech therapy and what works but it feels like a big battle." (Kathryn, social enterprise)

"Um, and at any kind of senior level you're having to fight a lot of battles you shouldn't have to fight." (Jo, NHS)

"So, we had been allocated half a day per week per area – that's what we needed to really fight for." (Sally, SE)

For Pamela, the struggle to justify her role contributed to her negative feelings of self-worth. Her account is evidence of her self-reflection and her understanding of the complexities around the feelings she has about herself. She began by attributing her lack of self-worth to negative feelings she has about herself – her feelings of not being '*good enough'.* She went on to wonder how being a woman, and how working in a '*minority profession'* had an impact on her self-worth. Finally, she commented on the relationship between not feeling valued as a profession ('*always left of this list*'), feelings of self-worth, and then needing to '*prove that you're good enough'*, i.e., to justify her worth.

"(I have) to rethink these negative beliefs about myself and *other people. That, I'm not good enough, I'm, I'm, I'm, you know – the imposter syndrome, um, if anybody looks, if anybody really asked me, or looked, they'd know. Shouldn't be here. I'm not capable. Um, and I don't know whether it's related to being female in our culture. I don't know whether it's related to, um, not being, um, you know, to being a speech therapist, which is a minority profession, and isn't really – like you, you know…We're always left off the list. You know, these are the trust abbreviations: OT, PT, Medic, [laughs]. No SLT. For a long time, that sort of thing happens. And I guess that's about then trying to prove that you're good enough?" (Pamela, NHS)*

Other consequences of feeling misunderstood and undervalued, and of continuous attempts to justify the value of what one does, were apparent in participant accounts. Some felt disheartened. For others, there was resignation about their work situations, and acceptance that they did not have the power to make changes, particularly after unsuccessful attempts to influence decision makers. There was a sense of having nowhere to go, of being stuck in the situations in which they found themselves.

"I think, I know this is about me, but I know it's not just me. My team, you know, feeling demoralized at times…" (Jo, NHS)

"Yeah, I don't know, I mean it's a bit 'pigs might fly' but there, there should be more, you know, National Guidelines for (SLT) staffing." (Jo, NHS)

"I've even had comments like, 'Why are you seeing that person with MND (Motor Neurone Disease)?'… And that's – when you've got NICE guidelines for MND that stipulate what the evidence base is, what the service should look like…when you have someone in a management position saying that to you, where do you go? Where do you go?" (Hendre, NHS)

"So, if (your role) is not recognised by trusts and people who actually are supposed to understand you, again – you don't have any confidence in your employers, do you? You don't feel valued, it doesn't feel [sighs]. What can you do?" (Carol, ex-NHS, ex-SLT)

"I don't know, I mean [exhales] we, we're stuck. Like for example, our autism service, um, we've been showing the commissioners the figures. You know, we've shown them the graphs, we've shown them what's happening, and they're still not giving more funding. What can you do?" (Anne, NHS)

As mentioned in the previous subtheme, a lack of monetary reward is one way that participants felt they were not valued for what they did. For Gwenneth, this took the form of SLTs in her team filling posts left by others that were on secondment – but who were then paid less than the original post holders and also, of most therapists having responsibilities that were above their pay grades. She went on to relay a conversation with her manager, where she shared the problem, but where the manager did not suggest any

changes, merely expressing surprise. Gwenneth's response is a further example of resignation.

> *"…what happens is, frequently somebody goes from one band to secondment but the backfill is a lower band. So that is not good culture…And this therapist who'd been emailing me about that said, 'I know that we all work above our band 99% of the time'…So, I've highlighted it, but you know – if (my manager) doesn't want to do anything about it, fine." (Gwenneth, NHS)*

This sense of resignation with how speech and language therapy is understood and valued did not occur in isolation. It was experienced within a context of resignation about constant NHS changes, illustrated by Sally's phrase; '*wishing for flying unicorns'* when she considered how she could have been better supported while working in the NHS.

> *"…managed by somebody who understood therapy, and … able to work in an environment that didn't keep changing. No matter what it was, if it was just a bit more consistent, a bit more stable. But that's like wishing for magic flying unicorns. (Sally, SE)*

Pamela expressed this resignation as defeat, alluding to having lost a battle. Like Kathryn, described earlier, she employed language with a military slant ('*defeated*'), suggesting she had been overcome by her adversity, and that she was powerless.

> *"One of the other emotions is, um, that I see a lot – not just in me, is, um 'defeated'. Defeated. It's like, 'We can't influence this. What's the point?' It's almost an apathy but it's, it's more than apathy. It's, we have tried, and we cannot do anything about this. There's a sort of powerless in that, but, on the other hand there is also – I guess it's because it takes energy and effort to, to, to persist." (Pamela, NHS)*

8.5 Subtheme 3d: Support – Formal Supervision and Informal Support

This subtheme provides insight into how SLTs viewed both formal supervision and informal support. Both were important to them, and if formal supervision was not officially provided by their employer, they sometimes attempted to arrange it themselves, demonstrating agency. However, there was a risk that doing this would exacerbate stress – because of the difficulty in securing supervision. Self-employed SLTs had better control over their supervision, with the result that they were more satisfied with this element of the job.

8.5.1 Formal supervision.

All the participants discussed supervision that was formally provided through their workplaces – some used the term 'peer supervision'; others spoke of 'clinical supervision'. For six of the ten employed SLTs, the provision of formal supervision was infrequent, not prioritised or ineffective. Gwenneth said that, where she worked, there wasn't '*any sort of official supervision'* and Carol explained how supervision was so infrequent as to be considered worthless. She went on to explain how supervision in the trust that she had recently left had '*disappeared*', because it was not valued. Willow, Kathryn and Anne's accounts further illuminated how supervision was not prioritised.

""…Band 7s, Band 8s, twice a year. Which isn't enough time, it's not enough, it's not frequent enough, is it? If things are building up. Which is why I think the clinical supervision at my trust was seen as a bit of a joke… the acknowledgement of the role of supervision wasn't there." (Carol, ex-NHS, ex-SLT)

"But it's quite easy to let supervision slip and I think I met with (my line manager) about three weeks ago and I hadn't met with her for almost 3 months, because of – you think, 'Oh, I'll go and sort that out, I'll go and book that in,' and you forget, and she forgets." (Kathryn, social enterprise)

"…we are meant to have peer supervision, um, and I think that's really good, um – since I've been here, which is… three years, something like that, um, I think I've had it twice? It's meant to be termly. Um, [pauses] no, I think twice, perhaps three times, but certainly no more than that. Um, and I certainly haven't had it, my last one was, um, July (seven months prior to the interview taking place)." (Anne, NHS)

"Clinical supervision was never prioritised over, um patient, so patient contact and meetings always came before that." (Willow, SE, discussing her time in the NHS)

Despite supervision being inconsistent, it appeared to be important to SLTs in this study. If supervision was not provided, some took responsibility for attempting to secure it. Jo described her difficulty in obtaining supervision; when interviewed she had been in her job for 10 months and had not had a supervisor allocated. For Jo, her lack of supervision was a constant underlying irritant, and she explained how she took control of the situation. Attempting to arrange supervision proved challenging for Jo – although she managed to identify somebody to supervise her, the need to '*persuade*' that person implied that this arrangement was not a natural avenue for support. Carol's attempt to procure external supervision was not approved, due to time implications, and was therefore unsuccessful.

"…I put forward the name of a potential clinical supervisor, so, because that's sort of not gone anywhere I'm trying to put together an external contract – which you wouldn't think was that difficult, um, I've managed to sort of persuade someone I've got to know…so I've had one clinical supervision with her, um, but just as a favour, so it's not really a… [trails off]" (Jo, NHS)

" I used to go across and meet up with a colleague from a neighbouring, um, authority, uh, but I was told that I couldn't do that because, um, of the time, im- impact. So you were only allowed an hour for your clinical supervision, but in order for me to get to her, it would be an hour's travelling. And they wouldn't allow me that time in work time." (Carol, ex-NHS, ex-SLT)

Jo also went on to describe how the boss of the person she persuaded to supervise her did not support the arrangement because the two SLTs in the arrangement had different NHS employers – this therefore had implications regarding which service was financing the supervision. Ultimately, Jo's attempt to gain supervision was not entirely successful.

Pamela's account demonstrates how, despite a lack of supervision arranged through her workplace, she managed to secure it for herself, revealing that supervision was important to her. She made the decision to arrange it and took some control of the situation, demonstrating a degree of agency. However, doing so required some dishonesty: in order to gain her objective, she '*cheated*'. Furthermore, the person who she arranged to provided

supervision was employed by a different organization. She felt that she shouldn't really be arranging this, that it was '*naughty'* – she had, in some way, behaved badly. Pamela again appears to personify the NHS – she previously stated that it '*beats you hard'*, she now describes '*cheating*' with someone outside of her organization. For Pamela, her behaviour altered the way she viewed herself – she felt that she became more independent, more unorthodox, '*a bit of a maverick'*.

"I'm not supervised by another speech and language therapist, above me, in terms of – or more experienced. Well, that's not true either. I am, but we cheat… I have been meeting up with another speech and language therapist from another trust... Um, and she is fantastic. And we get on really well, and it's a mutual respect and, um, support… we have called it peer supervision, and, and to all intents and purposes, that is what it is. Um, it's a different organization, so it's always felt a bit kind of naughty, these days, like we shouldn't really be doing it. Keep it under the [trails off]… There was no support, so I had to find my own way and that's probably why I'm a bit of a maverick…" (Pamela, NHS)

Anne described the effect that not having supervision scheduled in her diary had on her. Her account shows how, because supervision was important and necessary, if it was not timetabled it tended to happen unofficially. However, this '*unofficial supervision'* resulted in Anne feeling guilty and '*more stressed'* about an activity that is aimed to support therapists' practice.

"Cos just to talk to somebody about a case or about how things are, um, makes a huge difference. And, and, and (formal supervision) is a way you can do it without any kind of guilt attached to it – because peer supervision is something we're meant to do. Um, whereas if I turn to the person next to me in the office and we talk for 20 minutes about how things are, or the child I've just seen or whatever, then I'm thinking, 'Oh God, I'm meant to have used that time to write a report, now I haven't done that, and it wasn't in my diary so I haven't allowed time for it, so I'm now more behind and more stressed… it needs to be planned, it needs to be, you know, 'This is going to happen, we've got this in the diary,' and I allow time for this because this is part of what we do in our role, um, it needs to happen…" (Anne, NHS)

There was evidence that when supervision happened, it was not always effective. Sally contrasted the supervision she received as a self-employed SLT with the supervision she

had in the NHS – her description provided evidence that supervision in the NHS did not help to resolve difficulties. She also stated that her current supervision was not patronising (not a '*ah, there, there'* response), with a possible implication that she has experienced this in the past. Kathryn's account demonstrated employer acknowledgement of the need to restore well-being through *'restorative'* supervision. However, under the guise of support, organizational problems were ignored, concerns were trivialised, and Kathryn was expected to shoulder the responsibility for her own well-being.

"I felt (supervision) wasn't actually doing anything…" (Sally, SE – discussing supervision in the NHS)

"I know my manager is supporting me… so I can cope… It's not just a, 'Ah, there, there,' you know, 'You're alright.' [laughs]" (Sally, SE, discussing her current situation)

"So…there are a number of people that have signed up to be restorative supervisors and they're not part of your team so you can pick one of them and you go – and it's not counselling – but you can talk about work issues that you haven't managed to resolve within your team. And I decided to go and do it because I was sick of leaving work late. I'd promised myself I was gonna stop doing that [laughs]… And I talked about the fact that I – you know – was leaving work late and we talked through, well, what's making me stay late at work and it kind of came out with her saying, 'Well – nobody's saying you have to stay late.' Um. And then we talked about lunch breaks. 'Well, you are entitled to a lunch break.' [laughs]. 'What's the worst that could happen if you didn't – if you went home on time?' And 'What's the worst that could happen if you took a lunch break?' Um. And I said, 'Yeah, yeah, you're right.' You know, nothing really awful's gonna happen, is it? But actually, the work piles up if you don't keep on top of it. But I did feel it was kind of – was all put back on me. It was my problem that I was staying late at work. And we were short-staffed. 'Well, that's not your problem, that's the organisation's problem.' But we're short-staffed! I can't get through the workload!" (Kathryn, social enterprise)

Finally, Gwenneth's account revealed that the boundaries between clinical supervision and other less formal forms of support were not always clearly recognised or carried out in practice.

> *"People sometimes talk about supervision but actually it's not really supervision – you know, it's a bit of a chit chat." (Gwenneth, NHS)*

However, this '*chit chat'* appears to be crucial – it is the informal support that helped SLTs cope with daily difficulties and manage the emotional and psychological demands of the job. Informal support will be discussed in the next section.

8.5.2 Informal Support – facilitating the need to 'offload'.

How participants were required to support the emotional needs of service-users with whom they worked, and how this could result in anxiety, stress, exhaustion and time off work, was described in subtheme 2b: 'Emotional demands and consequences.' To protect themselves from negative emotional consequences, SLTs needed support to manage and process their own psychological and emotional reactions to their work; some reported receiving this support informally from colleagues. The need to be able to talk to someone to relieve worries or anxiety, was discussed by some. The word '*offloading*' (and sometimes '*unloading*') was used to describe the feeling of unburdening oneself. For Alice, this experience provided psychological relief through being able to express her emotions.

> *"I always, if I am feeling stressed, try and do things to help…like, you know, giving a colleague a call…" (Jan, NHS)*
>
> *"…I would have peers there that I could quite happily talk to… That, for me, that would be a really good opportunity to offload about everything… and was always very beneficial in terms of the cathartic feeling of, of unloading everything that was going on and getting that sort of practical day-to-day support and suggestion." (Alice, ex-NHS)*

Gwenneth described how she recognised a need for people to be able to share their concerns, and to be listened to, and how she initiated a forum to facilitate that. She was proactive, beginning by setting up a group for clinicians at similar clinical grades at which they would be able to talk, and recognising that a '*space*' in which to do so was important.

When this worked well, she expanded it to the wider team, naming the sessions '*Offload*'. By labelling the sessions, it is possible that she changed the perception of their importance and provided focus in terms of purpose – potentially a necessary strategy in the ongoing struggle to have the importance of informal support acknowledged. Gwenneth also used the term '*battle*', once more suggesting conflict.

"…I think it's so important when people are stressed to be listened to, and to have a space to say that. (We agreed) it was just a chance to offload stuff… about stressful situations as well and having a place to do that…" (Gwenneth, NHS)

"…we've done this thing the last couple of big meetings that we've had…where it's called 'Offload' and people can offload stuff and nobody else is allowed to say anything while they do it." (Gwenneth, NHS)

"So it's quite [sighs], it's just an ongoing battle to really get that recognised as being a valuable use of time. Somebody said they couldn't come to that meeting 'cos they didn't have time [laughs]. That says everything." (Gwenneth, NHS)

Seven of the employed SLTs discussed being informally supported by colleagues. For Jan, this support was crucial – during a particularly stressful period where she found she wasn't happy in her job, both her team and her manager provided crucial support. The role of peer support in protecting well-being and safeguarding one's enjoyment of a job was also apparent in Pamela's account. For Pamela, her peers provided a safety-net, identifying signs that she was stressed before she did.

"I had amazing support from my team, and my manager was brilliant… In that really stressful period last year I, I didn't like my job for a while, you know, for a good few months. I was resenting it, basically, 'cos I was really stressed. Um, so God knows what I would have felt like [laughs] if I didn't have that support there." (Jan, NHS)

"…we look out for each other, I think, on a team level. People can sometimes see the cracks before you can…" (Pamela, NHS)

Those with the responsibility of supporting colleagues tended to prioritise supporting their team over working on tasks that they themselves needed to complete. For Alice, this had

a knock-on effect of needing to take work home, which was linked to a fear of being struck off the HCPC register if she hadn't completed her notes in a timely manner.

'…and (the SLTs) would come in one at a time and they'd all offload, and they'd all cry. So I would spend all day dealing with everybody else. It would get to the end of the day and I would think, 'Oh crikey, I haven't written any notes yet, I need to go home because I've got to get the kids,' [laughs] so I'd go home, I'd get the kids and then I'd get my laptop out and I'd sit and write all the notes. That I hadn't written during the day – because I didn't want to get struck off (the HCPC register) for not writing up my notes in a timely manner." (Alice, ex-NHS)

The need for frequent support was evident in participants' accounts. Having to wait for months for the help to process an emotionally difficult experience, could result in frustration. More regular and timely support allowed SLTs to share experiences and thus enabled some dissipation of their frustrations.

"…it might be that you see, yeah, a patient that you find difficult, you know, emotionally, and then you're not going to see your supervisor for another two months, or whatever." (Jan, NHS)

"…you know, the times that you needed to actually speak to somebody about a situation, was now… And I think that was a frustration as well. Not being able to speak to somebody necessarily when you needed to." (Carol, ex-NHS, ex-SLT)

"Um and having a colleague that you can go and say, 'Ugh – I've just had this awful visit'. And sometimes being a little bit irreverent about people. We'd never be unprofessional in front of a patient or a carer but sometimes you need to come back and offload and say, 'That person has really done my head in today!' or 'Their carer was really rude to me, and – you know – I had to stand there and put up with that.'" (Kathryn, social enterprise)

"…like all the time, like all the time, like people are – they make themselves available and you can come and say like, 'Ah, I've had a really stressful session, I felt really like X, Y, and Z,' and somebody's going to listen to you, like right then and there." (Susan, NHS)

Kathryn went on to suggest that support for everyday concerns was sometimes not recognised by employers, who focused on other ways to support staff. Her mention of '*day-to-day issues'* was suggestive of work that might be continually frustrating, and the lack of support for these issues might be indicative of an unawareness, inability or unwillingness on the part of the managers to address job design features. In addition, Kathryn's feeling that her managers had been on an '*active listening course'* suggests that she was not convinced they had the skills to support staff emotionally or psychologically.

> *"They've now got somebody who's sort of in charge of that well-being, recruitment and retention. But I went to a forum recently and although they seemed to be listening more and it was almost like some of the managers had been on an active listening course [laughs]. They were all talking about – well – we're going to rebuild lots of links with the universities so people could go and do a Masters and PhDs and I thought, 'Well, that's great – but it doesn't address the day-to-day issues.'" (Kathryn, social enterprise)*

In addition to support from colleagues or peers, participants discussed the support they accessed outside work. Some of this support was through friends who were SLTs, but participants also sought support from family members and non-SLT friends.

> *"And talking to friends and, um, a couple of friends who, well, one used to work for the really big acute hospital in (a large city), so, she knows what it's like…" (Jo, NHS)*
>
> *"I had plenty of support from friends and family, so I was happy with that." (Alice, ex-NHS)*

Four participants described counselling that they had received outside of the workplace – two had arranged this themselves, one had attended sessions organised by her employer during her sick leave, and one had had experience of both. All explained how these had helped them to manage the emotional demands of their jobs, and all discussed sharing what they had learned with colleagues. Jo's account demonstrates how the ability to understand one's emotional responses to experiences is an important part of an SLT's job; needing to learn these skills through counselling suggests that they are skills that are neither developed during pre-qualification training, nor taught as part of the CPD of an SLT.

“And I suppose the thing is, it, makes me ultimately a much better clinician because I’m much more aware and I can tackle these sort of difficult emotional cases, um, at work, because I’ve reflected on myself, um, and relationships with colleagues and how to manage something and, you know, why am I reacting like that, and, yeah.” (Jo, NHS)

8.5.3 Self-employed SLTs: well-supported and in control.

The self-employed SLTs, on the whole, received levels of supervision and support with which they were satisfied. The paediatric SLTs who were not part of teams at a workplace, explained how they had developed relationships with school staff members to ensure that there was support for them. For Ruby, this reduced the burden of responsibility that she carried. Sally’s account revealed how she accessed clinical supervision as and when she needed it, from individuals who were knowledgeable in the different areas she might need help. Her network of SLTs ensured that she was well supported.

“I have pretty good relationships with the teachers in those schools, and particularly the SENCOs… And so, in terms of feeling supported… I’m not alone with the responsibility of (a) family… or if I felt that I needed some, um, support, in, in managing a situation, for a positive outcome, then actually I would have access to people that I could actually share that with. So that, I think, actually reduces some of the, some of that sort of load.” (Ruby, SE)

“…I’m part of a network of therapists so I can ask other people… Um, I think it’s very informal so it’s when, when you need advice, you kind of look around you and see who’s available, but also knowing who knows what…” (Sally, SE)

Like Sally, Willow (who worked with adults) was part of a network that enabled her to seek relevant support, depending on what she needed help with. Willow’s account also shed light on how self-employed SLTs viewed supervision. It has been demonstrated that some of the reasons employed SLTs struggled to secure supervision included travel time to supervision not being approved, and monetary issues e.g., colleagues having different employers. Self-employed SLTs, however, accepted that time spent receiving or providing supervision was not typically remunerated. They recognised the importance of supervision, had control over how it was organised, arranged it to meet their needs, and were satisfied with the support they were receiving. Willow’s account is evidence of many of these

concepts. She had agency over how she negotiated her support, and control over how this support was realised in practice. The result for her was satisfaction with how her support was managed.

"So now, I have a great support. I have loads. So, I get it in quantities that I feel are appropriate. So, I have it from several different places. Um, I have it with a therapist who is more experienced than me… Um, so, with her, I will tend to, I will talk about any emotional, you know, well-being type things, or things that, you know, I'm finding difficult. But also, cases. So, we brainstorm things together, we share resources…And we do our annual appraisals together. So, we actually do an annual appraisal and set goals and that kind of stuff. So, I probably see her [pauses] once every 2 to 3 months? For a half day… for me that feels a little bit more like a line-management in a way…I have another, there's another therapist… the supervision I get with this other therapist, is very much peer supervision. So, we help each other with cases, you know…" (Willow, SE)

"…a lot of my friends are speech therapists…maybe half of them. Um, and, and I've got friends who work in, um, research. I've got friends who work in clinical roles. I've got friends who work in charities. So depending on what I'm wanting some supervision with, I'll kind of ring them and say, 'Oh I've got this person I'd really like to talk to you about.' Um, so I would say I get more supervision than I even did, I think, in the early days in the NHS. But it's all unpaid time, for them and for me." (Willow, SE)

Lesley and Ruby also discussed being well supported, their experiences were of frequent support, which included both organised supervision and was also built into their relationships with friends who are SLTs. Both had control over how they wished to be supported and were satisfied with the arrangements in place.

"I am in a position where I feel really well supported because I've got a fantastic, um, colleague peer group, um, that we meet regularly. I have, um, a close friend who is also a speech and language therapist, so we, we are able to support each other at any time – whether it's clinical or non-clinical related to work." (Lesley, SE)

"I'm quite fortunate in that I have a couple of very good friends who are also very experienced speech and language therapists. And so I am quite able to call upon, you know, those friends – stroke – clinicians for clinical support and also within that, because

they're very experienced therapists the things which I find difficult which probably are not clinical questions… And the interesting thing is that, um, back to that kind of, uh, formalised support, which I don't have access to, but – one of the, um, the friends and therapists I see pretty much every week… every week we talk about, 'How's your week been, what have you been doing?' and we talk in quite a lot of depth about the, you know, the – what will have come up in that week...So I think that the oppor- if I didn't have access to, to that kind of quite regular – although I do seek it when I need it, but actually, it is kind of built into my, my relationships." (Ruby, SE)

Both Ruby and Lesley also described support from their husbands, something that was not mentioned by the NHS SLTs. Both made it clear that they did not compromise client confidentiality, but that they were able to share their frustrations at home.

"(My husband) provides quite a good, um, supervision kind of role but not really, he – I will offload a lot of… on a daily basis I will offload emotional stuff about things that have happened at work and … he doesn't offer (to help) – and that's what I need. I just need to dump. I just need to offload, and not be offered suggestions on how to fix it. Because actually I know what to do, but it's just that offloading…" (Lesley, SE)

"I have a really supportive husband and … I will actually, I will, you know, vent at home." (Ruby, SE)

The only self-employed SLT that felt that she needed more supervision was Isabella, who provided a contrast to the other self-employed participants. Her account demonstrated that she took responsibility for arranging, and paying for additional supervision when she needed it. However, although she had access to various avenues of support, she thought that more supervision would be beneficial. This might suggest that support alone is not sufficient in protecting Isabella's well-being, but that there is possibly a need for other changes to her job and/or her strategies to cope with the job.

"And for a while there, when I was super-stressed, I, um, had a supervisor that I was paying, and I had monthly supervision, but then that kind of fell by the wayside. And I do think it's really important, so I do need to prioritise, um, getting back into that… And myself and some colleagues have set up a peer supervision group…it's probably, realistically, every three months… obviously we have peer supervision in the team meetings, as well

so, and that happens every six weeks. But, yeah, we all feel it's something we want more of. It's just [unintelligible] busy jobs, trying to meet up [unintelligible] But, I mean, I've got one colleague who I'm close friends with, um, in (a neighbouring area) as well, so often we just message each other or call each other, and like, 'Hey, do you mind…' or whatever. So…" (Isabella, SE)

8.6 Summary

Feeling understood and valued by others was important to the SLTs in this study. However, participant accounts revealed that the profession is not understood by others. This lack of understanding is pervasive – from commissioners and managers, to non-SLT colleagues who are health or education professionals, and by the public generally. Furthermore, a lack of understanding by others is coupled with many SLTs feeling undervalued, resulting in frustration and anger. There was a sense of inevitability regarding this lack of value and of the profession needing to take responsibility for the status quo. Feeling undervalued meant SLTs felt compelled to justify their professional roles, and in effect, themselves as people. Both a lack of understanding and not being valued was deleterious for some. Consequences included negative feelings, a lack of self-worth, loss of hope, defeat and resignation. Finally, a lack of feeling valued led to some SLTs leaving the NHS.

SLTs in this sample who were employed discussed their lack of support, both in terms of formal supervision and informal support at work. Formal supervision was, at times, infrequent, not prioritised, and ineffective. Nonetheless, supervision was important to the SLTs and several took responsibility for arranging it if it was not provided, demonstrating some agency. However, because this was sometimes unsanctioned, it could lead to feelings of guilt and increased stress. Informal support was seen to relieve worries and anxiety, meaning that the resulting psychological and emotional relief protected well-being and safe-guarded the enjoyment of the job. It was felt that support needed to be frequent, in order to address the daily, ongoing stressors at work. Some SLTs sought support outside of work – from professionals e.g., counselling, or from friends and family. SLTs who were self-employed provided a contrast to those who were employed. Their increased autonomy meant that they were able to arrange frequent supervision and support; most reported that this was effective and they felt satisfied with their arrangements.

CHAPTER NINE: SUPERORDINATE THEME FOUR
FEELING CONFLICTED, BEING IN CONTROL

9.1 Overview of Superordinate Theme Four

This superordinate theme explores experiences of conflict and control for SLTs. All the participants in this study contributed to the theme. Conflict around expectations about how SLT services are delivered resulted in discomfort, anger, exhaustion and strain for participants. Furthermore, the quality of some services was perceived to be poor, and the values of several participants were compromised, resulting in cognitive dissonance and questions regarding the self and identity. Struggles to gain some control in an attempt to resolve conflict were evident; with different strategies being employed to do so. Conflict was not limited to those participants who were employed, although the self-employed SLTs experienced conflict for different underlying reasons. They are therefore discussed separately in this section.

Superordinate Theme Four	Subthemes
Theme Four: Feeling conflicted, being in control	4a: Conflicting expectations 4b: A lack of control 4c: Consequences of a lack of control 4d: Resolving conflict: strategies used

9.2 Subtheme 4a: Conflicting Expectations

One source of contention for participants who were employed arose from them having different expectations to their employers (largely the NHS), regarding what and how SLT services should be provided.

Willow's description of her experiences illuminated what it meant for her to be able to work in a clinically effective way, and her resulting discomfort if she was thwarted from doing so due to service constraints. Being '*prevented*' from delivering what she believed she should be providing suggests a feeling that there was active prohibition by decision makers that impacted on her ability to do her job. This conflict between what she '*needs*' to give and what she was able to provide meant that Willlow's values were compromised. She was unable to affect change, she lost her sense of utility, and she felt undervalued. Moreover, should she be challenged by service-users, she believed she could not argue in support

of service decisions, that to her were indefensible. This ultimately contributed to her decision to leave the NHS.

"…at that point I was working in an AAC (Alternative and Augmentative Communication) assessment centre and we always saw them for an assessment ***process****, not an assessment* ***appointment****… we'd see that patient, and their local therapist, 10 or 12 times to make sure we'd got the right device, to make sure everybody was trained up, to make sure everybody knew how to use it, to make sure that the speech and language therapist who had no experience of AAC had some, you know, knew how to implement this. It's not something that you can, you know, it's like a car – you don't just give someone a car and expect them to drive without any lessons. And that was being eroded, so, you know, you can, you can have six sessions, no, you can have four sessions, no, you have to do it in three. And I just thought, 'Ah, no, it's not fair on the patients, it's not, it's not fair on the local speech and language therapists, and I'm not enjoying this because I'm not doing a good a job, so I'm not feeling useful, I'm not feeling valued, I'm not giving what I know I need to give. I'm being prevented from giving what I need to give… I felt I was prevented from doing some of the things that I felt would make a difference. Um, and that does not sit comfortably with me. I, how do I justify that to a patient?" (Willow, SE)*

Carol's experiences illustrated a disparity between what she felt was part of her role, and what she was able to provide. Her phrase, '*trying desperately'* gives insight into the strain under which SLTs found themselves to be when attempting to practice effectively within service constraints. Carol's unwilling acceptance – '*struggling to toe the line'* – of authority also resulted in conflict. For Alice, defending what she understood to be good practice, in the context of a service that was designed to maximise patient numbers, was exhausting. Alice's need to defend her position suggested conflict.

"…therapists… are trying desperately to balance what they want to be able to do with what they know they are limited to in terms of time and money and all the rest of it. Then you've also got people like me who know what we used to do and how things have changed greatly, you know, and it just, it's, it's hard...(I) have struggled so much to sort of toe the line – working in the way that the Clinical Commissioning Group and the trust I worked for were prepared to fund services." (Carol, ex-NHS, ex-SLT)

"And constantly trying to fight your corner for why you've only seen two people…' (Alice, ex-NHS)

During her example of one of the ways that the service for which she worked was currently delivered, Anne became visibly annoyed – there was tension in her body, the colour in her face rose and both her pitch and volume increased as she spoke. Being required to fulfil tasks that were not in the best interests of service-users made Anne angry, and left her with a sense of futility at having to satisfy service procedures that have little merit, arguably a waste of limited resources (Gallagher, 2015).

"…Whether it's justifying it to myself, or whether it actually ***is*** *reasonable for that child – 'cos sort of I'm thinking, 'This family's had absolutely nothing from us. This is the first thing they're gonna have from us and I don't want it to just be half a page [laughs] of, you know, for example, for the telephone consultations – basically we send a report (to service-users) saying, 'This is what you told us.' And I think, 'Well, what's the blimming point of that? They know what they told us!" (Anne, NHS)*

9.3 Subtheme 4b: A Lack of Control

Conflict around expectations regarding the way SLTs practise was linked to the influence they felt they had in their daily working lives. The experiences of those in the NHS were characterised by little control over the determination of how a service was delivered (e.g., through clinical pathways), as seen in Sally's account. Her comment about what one is able to do alluded to a sense of being incapable of acting differently due to constraints imposed on her – she felt powerless. Carol's feeling of powerless came from a recognition that the clinical commissioning group had control through funding.

"…it was very, very prescriptive about what pathway you could offer the child...And I understand that's to do with resources and lack of resources… Actually, there's something else you need to know about autonomy… It is not just what you're ***told*** *to do, but also what you are* ***able*** *to do." (Sally, SE, talking about working in the NHS)*

"The CCG inhibits (autonomy) in as much as they will only fund what they will fund." (Carol, ex-NHS, ex-SLT)

For Anne, the connection between having little autonomy and the inability to affect change was clear. Her account alludes to tight prescriptions with little room for movement which would allow for evidence-based, clinically appropriate dosage. Anne was upset while describing what for her felt like inadequate provision that threatened the quality of care that she is charged with providing as an SLT (HCPC, 2013).

"I think that probably what is most difficult at the moment is just feeling that, um, you know, we have long waiting lists, so I'm told, 'Yeah, you can pick up that child for however many sessions,' and they've been waiting for, I don't know, six months or whatever, and um, just feeling 'Well, this is a complete drop in the ocean,' and 'What's going to happen next for that child?' because that's not going to be enough for the child… And then stuff we're doing, I can't necessarily see that it's working" (Anne, NHS)

As frontline staff, SLTs may also be put in the position of having to communicate available provision, which they may perceive to be inadequate, to service-users. Susan's experience had a negative effect on her feelings, as the service provider. When discussing her frustration with aspects of the job, Susan became tearful. The vocabulary she used – "*unbearable*" and "*horrible*" – alluded to an intolerable experience, and suggested that she expected, as a clinician, to provide something different, but was unable to do so.

"So the pathway that we're working at the moment…we see children for screening from two, and if we think they have autism spectrum disorder, we're not allowed to put them on a therapy waiting list, we can only put them on a diagnostic waiting list, which is a year, and then we know that after that, if they get the diagnosis, which sometimes (unintelligible) sometimes I'm very certain that they're going to get the diagnosis, and then they can be waiting for another year [laughs] and you have to tell them. You have to tell these parents of a two-year old that we have no therapy until their child is nearly four. And it's unbearable. [exhales] Horrible…I don't know, I didn't come into this job to have people come and ask me for the help and me tell them I wouldn't help them." (Susan, NHS)

The lack of control that participants in this study experienced was not limited to diminished autonomy regarding broader service delivery but was reinforced through other means. One example of this was the homogenization of the intervention that SLTs were able to provide. Sally described it in terms of available therapy packages, where therapy groups included children with very varying clinical needs, who were then offered the same intervention. Her

account made it apparent that this strategy may not be viewed by SLTs as the most effective practice; she used humour to alleviate her sense that the situation effectively flouted a core HCPC (2013) competency, i.e., to assure the quality of one's practice.

"One size fits [pauses] hopefully somebody [both laugh]. That's awful." (Sally, SE, discussing working in the NHS)

Control for SLTs extended to choices regarding how therapy is delivered i.e., what happens during therapy sessions. For those employed in the NHS, accounts regarding their autonomy around therapy varied. While Jan and Willow felt they had this level of autonomy, others did not. Susan resisted the constraints present in the service for which she worked, echoing Willow's earlier comments about defending her clinical decisions. She was aware of her responsibility, under her professional registration, to practice effectively and alluded to a level of autonomy implied in the professional role, *'…we're therapists. We can make a decision'*.

"I feel like I have [pauses] control over what I decide, like what therapy… with my patients." (Jan, NHS)

"…I still had autonomy in the ***way*** *that I delivered my therapy…" (Willow, SE, discussing working in the NHS)*

"I think, and also within the sessions there's lots of kind of set session plans and, like a lot of my colleagues feel like they have to follow the session plan, and like, you don't. And I always really encourage them not to [laughs] because at the end of the day it's your registration and you have to do, like what you can defend if it comes to it. Um, like and also, like we're not assistants, we're therapists. We can make a decision" (Susan, NHS)

SLTs in this study also felt that they had little control over their workloads, the increase of which sometimes stemmed from government initiatives, and added to their responsibilities. At times, they questioned the value of some of these initiatives. Sally recognised that having control over one's workload would impact positively on one's well-being.

*"… every time the government announces a new initiative, we're all gonna be responsible for this now… It's **another** thing." (Kathryn, social enterprise)*

"…it's just yet another thing, and another thing, and there's another thing, and, and sometimes it seems like; why are all these things being put on us, just to make our lives more difficult? Does it actually do any good?" (Anne, NHS)

"I think being able to feel like you have a say over your workload or how you do your work would also have a massive impact (in lessening stress)." (Sally, SE)

Control over workload was further eroded through the incidental demands that SLTs were subjected to, for which they were unable to plan, and for which they did not have time allocated. Once more, the language used to describe such experiences is revealing – Gwenneth said '*things that get flung at you*', reinforcing a sense of lacking control.

"…I picked up the phone and it was a parent giving me an update and just as he was speaking my heart sank. Because I thought, 'Right, okay. Now I've got to phone the high school this boy's at. Now I've got to do a few things,' and I just thought, 'Right. How am I going to fit all this in, because I didn't expect this, this week?' And that's a real challenge. It's the things that get flung at you. From all directions." (Gwenneth, NHS)

Participants' accounts suggested that managers responded to service-level pressures by imposing their own controls on colleagues, meaning that another layer of control was enforced. This further stifled the autonomy that SLTs had, leaving them feeling restricted, with little freedom to make decisions. While Gwenneth explicitly mentioned feeling suffocated, Hendre demonstrated this through miming choking – both expressing a sensation of not being able to breathe as a result of management styles.

"I just found (the management style) suffocating." (Gwenneth, NHS)

"…this management strata coming in…caused a lot of clashes because they were trying to control us so much and decided that, 'You're not doing that, you're doing this' and it was all linked to targets and them looking good… her style was [making a choking sound] control." (Hendre, NHS)

At times, there was unabashed admission by managers that there was no expectation to provide excellence, possibly making the defence of service constraints that compromised quality more palatable. Alice's account described this lowering of standards by management as a direct compromise of her requirement to assure the quality of her practice. The decision to provide a service that was, in the views of some SLTs, sub-standard, may have also been unwittingly supported by newly qualified SLTs who had never experienced working in a service that provided strong, evidenced-based support. Jo described this as an SLT being '*a product of her time'* and went on to explain that newly qualified SLTs may only have worked in services where '*firefighting*' is the norm. Her use of the word '*firefighting*' alludes to an environment where work does not take place in a calm, planned manner, but problems arising are managed within a reactive culture. According to Jo, a possible result of SLTs never knowing a different way of practising, could be a lack of activism, or advocacy that is needed to affect a change in the status quo; and ensure the quality of practice that registration with the HCPC requires, and that is urged by the RCSLT (2019).

"I was told that I shouldn't expect to deliver a gold-standard service to my patients, I should only expect to deliver a silver-standard service… I think I have a professional responsibility to deliver a gold-standard service. I think that's what I signed up for in the first place." (Alice, ex-NHS)

"(A newly-qualified colleague of mine) doesn't know what a gold-standard speech and language therapy service, or even a half-way decent speech and language service looks like. She wouldn't know how to do communication therapy, and that's not her fault. She's a product of her time... but she won't be the one that affects change because she does accept this – she's only ever worked in one place, with this kind of firefighting. So, that's the norm to her, I guess" (Jo, NHS)

A further method of controlling the way that SLTs were practising was through dictating the language they could employ when communicating with service-users. This method of control was not limited to the SLTs but appeared to be an attempt to control the expectations of service-users. Both Anne and Sally's accounts included experiences of this, with Sally's description providing some insight into the strategy.

“For a high priority child, we’re not allowed to use the words ‘high priority’ in our reports because people expect something to happen, which it then doesn’t” (Anne, NHS)

“… they got in some company to come and train all the therapists up in – I can’t remember what they called it – but basically it was to do with avoiding complaints. It was to do with making sure that the person you are giving the advice to feels like they’re getting good advice. And that they’re getting a good service. It’s complete marketing [pause] rubbish. Um, it was little things like, um, you know, not setting expectations too high – setting them too low, so that when you give them stuff, they feel like they’re getting extra. Um, or, you know, what words to avoid using or things like that. And we all just kind of felt at the end of it, really exasperated, because what they really were trying to – we felt – say to us, is, um, that we needed to make sure that schools and teachers and parents felt that the service that ***we*** *didn’t think was good enough for their children was really amazing. And that type of thing is just nonsense, isn’t it?” (Sally, SE)*

The apparent need to control how a service was portrayed and therefore the way service-users viewed that service, leads to questions about existing provision. These include whether the need to enforce strictures around language used to communicate with service-users would exist if those service-users were satisfied, and whether it would arise if service providers believed the service to be of an acceptable standard.

The removal of autonomy was not limited to practices within SLT services but occurred at broader NHS trust level too. An example of this process of standardization was the incidental homogenization of AHPs when they were grouped together. Participants’ accounts demonstrated how, because SLTs are a relatively small group, when they were grouped with other AHPs the shift in practice tended to be away from SLT-specific procedures and towards processes typical of the therapies that were better represented. Some felt, however, that this standardization was not appropriate, resulting in irrelevant – ‘*useless*’ – targets.

“Um, and maybe having to use outcome measures ‘cos they were the trust’s outcome measures that were useless for speech therapy...” (Willow, SE)

"…even in our team … there was a focus on everybody – every discipline – doing absolutely everything in the same way… there's sort of a move to have standardized treatment plans which – I don't want to disrespect any other discipline – but I know in physio they have – um – online resources like "physiotools" so they can pick a selection of exercises for people and then (unintelligible) to say, "Well, why don't you have that in speech therapy?". And you can come up with very similar treatments for people but you wanna try and tailor-make it." (Kathryn, social enterprise)

The lack of control experienced by SLTs may also carry an element of risk for service-users. Ruby explained being directed to do work that was not within her skill set, and which she therefore felt would be putting vulnerable children at risk. This experience links to subtheme 3a describing a lack of understanding of the profession. Once again, a core HCPC (2013) standard of proficiency was compromised: to be able to practice safely and effectively within one's scope of practice, and to know the limits of one's practice. For Ruby, this was the '*tipping point'*, her response to the experience was to leave the NHS.

"I was saying, 'I really do not feel that I am equipped to do that, or that I would be safe to be doing this. I feel I need you to know that this is not something that I feel is within my skill set, and experience. And also, it's not the job that I applied for and that you pay me to do'. Um, but, because I was being directed by somebody who was from outside of my profession, but ultimately they paid for my service I had absolutely no autonomy over that decision and actually, essentially, um, that had a large part to play in my decision finally that this wasn't really – that being put in positions such as that were not something that after X number of years of qualified working, I should find myself in. And that I was not, did not feel safe to be put in a position where I could be asked to do something so outside of my skill set really, for children who are very vulnerable. Um, so, because of that, that had, that probably was the tipping point – within the context of everything else." (Ruby, SE)

Another aspect of autonomy was evident in the accounts of those that had been working for longer – control held by SLTs had been dwindling over time. Both Anne and Willow described this, with Willow also commenting on how this compromised her ability to use the evidence base effectively in her practice. Inability to engage in evidence-based practice would arguably prevent a clinician from successfully affecting change – already identified as a source of uneasiness for SLTs.

"…it's just so different from when I was working on my own, in the health centre, doing my thing, making my decisions, um, making my own judgments as to whether therapy was working or not – now I'm in a place where, um, obviously I need to follow very strict pathway guidelines… I know that how I'm feeling about work is a lot dependent on how in control I am." (Anne, NHS)

"…over the last six years, my final six years in the NHS, um, I felt less and less autonomous. So, some of the evidence-based practice I couldn't put into practice because I could only see people three times… I felt that, that my autonomy was really eroded." (Willow, SE)

A contrast to the general experiences of lacking control was evident in Jan's account. Jan felt that she had flexibility over her working hours and also that she was protected as a Band 5 SLT – meaning that she had control over which patients she saw. Jan was the only employed SLT to speak positively about control; she acknowledged that this might be partly because she is a relatively newly qualified SLT.

"Um, I think as a Band 5 you have a bit more control over what patients you see and what patients you don't see. So if there was something that was particularly complex, then you know, like my Band 6 would [laughs] want to protect me a little bit as Band 5. And, you know… I feel like I have a bit more control over that, about saying 'yes' or 'no' to whether I, you know, would like to see a more complex patient or not. Um, and also, I think, this is particularly in community, you have control over like, your hours. Because it's flexible…" (Jan, NHS)

9.4 Subtheme 4c: Consequences of a Lack of Control

The inability to control the level of input that service-users received, or the timing of services offered, affected the well-being of SLTs in this study. Willow felt '*rubbish*' and embarrassed that she was letting service-users down. Moreover, she acknowledged that the result of not providing adequate services might be that other professionals would not value SLT services, which is linked to the third theme 'A lack of validation, feeling unsupported'. The many emotions that Gwenneth recalled when describing a specific decision over which she had no control were testament to her strength of feeling at that time. Her feelings included '*really, really frustrated…quite angry…such a low*

*point…bitterly disappointed (repeated twice) … so, so ups*etting'. The unhappiness she felt over level and timing of input was associated with a lack of trust in management.

"…even though I know that this is your diagnosis and I'm telling you that this is what you need, I'm actually going to give you this. I mean [trails off]… you feel rubbish… I felt like I was letting patients down, um, I felt embarrassed. And like, for example, if these people were then going to another service, and they'd go, 'Is that what (speech and language therapy) has done?' [Willow looks incredulous, disdainful] Um, so, you know, embarrassed, yeah. Um, what else? Yeah, just, not good. Not good for your well-being." (Willow, SE, discussing working in the NHS)

"…something I got really, really frustrated and quite angry about… we were working with an improvement leader… we got our waiting time down to two weeks and we were managing it. And it was absolutely fantastic… Then, we were told that our waiting time was too low, it made all the other localities look bad. So rather than the other localities learning from us, we were told we had to let our waiting time go back up again. And that's just such a low point for me… I was bitterly disappointed because where I work, there are some high levels of poverty… we had managed to create a service that got them in the door straight away and it was the best for these children. And then we were told we couldn't do it. So, it was so, so upsetting. For all of us. We were all bitterly disappointed about that. And lost a lot of faith in management, I suppose…" (Gwenneth, NHS)

Others described feeling demoralized and '*terrible*' due to the lack of time that they were able to spend with service-users, and which, again, they were powerless – '*not allowed'* – to change.

"……yesterday I had to see a patient with cerebral palsy, and he'd been in two weeks ago with chest infection. And it might have been near the end really, and he was back in a sort of terrible state. When he's relatively well you can understand, sort of, some single words that he uses. Now (his speech was) very ataxic and I could not work out, with little time, what he was trying to spell, or what he was trying to say. And, and then, yeah, I felt pretty terrible, just leaving him…" (Jo, NHS)

"The frustrating thing is that we're not allowed the time to be able to work with… families, be effective. I think that's something that adds to the demoralization of the staff." (Carol, ex-NHS, ex-SLT)

Participant accounts demonstrated how, when beliefs and actions are incompatible, there is resulting conflict around how it feels to be an SLT. For Pamela, this was expressed as impacting on her identity, she reluctantly recognised that her job as an SLT forms part of who she is, and her implicit admission that she could not relinquish this part of who she is could mean that she cannot leave her profession but is required to manage any conflict that arises as part of her work.

"I'm quite torn in terms of my identity, I think. I didn't really think about whether (speech and language therapy) is part of my identity because whenever I got fed up with it, I thought, 'Well I, I just sort of fell into this really. I was supposed to do something else.' So, I've always – when things have got seriously bad, I've always thought, 'Oh, uh, maybe I should have been an artist, maybe I could still be an artist.' And it was only when a colleague said, when her job was at risk, she was Head of Paediatric Speech and Language Therapy, her job was put at risk, and she said – they'd offered her something else, managing lots of other paediatric services. And she said, 'But it's my identity that's being threatened. It's my whole identity.' And it really made me think whether, if the same happened to me, whether I would feel the same. And I think that's the case…I have rallied against that, as being the only thing that defines me…" (Pamela, NHS)

Ruby's experience also had an effect on her sense of self as an SLT, she felt she was not behaving according to her beliefs. Reflecting on working in the NHS, her account alluded to having to compromise on her standards, and how she was forced into an inescapable position. In addition, her comments added to those of Susan and Willow in that she felt that clinical actions that she was required to take were not justifiable. This resulted from being managed by somebody who did not understand SLT, a theme highlighted previously (subtheme 3a).

"I felt frustrated that maybe I was being asked to do things which I felt were clinically, um, either irrelevant, or actually, sort of indefensible – uh – that I felt that I wasn't being true to myself as a therapist, doing the things I knew that I could do well, and doing them well, and sometimes I was asked to do things I didn't feel (were) actually right for ***me*** *to be doing, that I had the appropriate skills for – but might be cornered into doing by a senior manager who didn't understand my profession." (Ruby, SE)*

Susan went further, to describe the conflict that she felt as 'cognitive dissonance' – she was aware that her actions were not aligned to her values or beliefs, and this led to intensely negative feelings about the service she was providing. She mentioned this discordance again, when questioning how she and her colleagues would be able to align their actions to their values.

"…it is actually unacceptable, like the care package we give is too small, and we're not meeting the needs of people, and I hate it, um, it's a big cognitive dissonance, like every day. Like, 'Why am I doing this, because I don't think it's right?'" (Susan, NHS)

"And it's what I talk about at every supervision, and my supervisee talks about it at every supervision – like, 'What are we going to do? Who can we say 'no' to?' Like how will we square that with ourselves? Because I think that's somebody we need to say 'yes' to, really, but we can't." (Susan, NHS)

Jan again provided a point of contrast to the other participants. When asked how she felt if she was unable to see patients as frequently as guidelines recommended, she did not express any conflict or negative feelings.

"I think it doesn't worry me too much… I think we try our best. And that's all we can do. So I kind of feel like you can only do what you can do, and we will try our best to, you know, to follow the pathways, follow the guidelines and give them the best input possible. But, at the end of the day, I don't think we should be pushing ourselves over the edge to do that if it's not possible. And we will just do what we can. Yeah." (Jan, NHS)

9.5 Subtheme 4d: Resolving Conflict – Strategies Used

One of the HCPC competencies for an SLT is to "be able to practise as an autonomous professional, exercising their own professional judgement" (HCPC, 2013). The notion of autonomy is one that is introduced to SLTs early in their undergraduate training, reinforced during clinical practice while a student, and expected in order to maintain membership of the profession's regulatory body. Finally, it enables SLTs to think critically (Gallagher, 2015). If this autonomy is thwarted, SLTs in this study appeared to strive to regain it.

Participants in this study attempted to resolve conflict through implementing various strategies that enabled them to take back some control. Seven of the ten who were employed demonstrated agency by describing actions that they undertook to achieve control. Reclaiming control happened in two ways. Some engaged in behaviours during their daily working lives that would resolve conflict. Others chose to leave their jobs.

9.5.1 Taking control within the NHS.

Some of the SLTs employed in the NHS regained control through measures that were unsanctioned by managers or the trust. The figurative language employed when describing methods used to regain control e.g., operating "*under the radar*" or "*playing a game*" hinted at a degree of deception or manipulation employed by participants, when attempting to achieve some control and do what they believed to be right.

"I did what I felt my families needed. And I can remember saying to staff sometimes, if you feel that you need to do that, then that's fine – just don't make a big fuss about it, and don't let (management) find out..." (Carol, ex-NHS, ex-SLT)

"We have a joke in our little team, that we do things 'under the radar' and then we tell the team leader what we've done. So we're currently doing a bit of that at the moment because we're trying to think creatively about how to manage the referrals." (Gwenneth, NHS)

"…if you know the system, and how to work it, then you can have some autonomy…you have to play a game a bit, don't you?" (Jo, NHS)

"I just very quietly ignored what we were being told to do [both laugh] and funnily enough, six months later the other disciplines had gone, 'Do you know what? We're going to do what the speech therapists do 'cos that works better.'" (Kathryn, social enterprise)

Furthermore, some vocabulary used by participants e.g., '*stolen*' referenced behaviours that are viewed negatively in society – Susan acknowledged that the course of action she took was somehow iniquitous even though it would facilitate what she felt would be an improvement in the service. However, her somewhat clandestine actions to gain some control were sometimes implicitly supported by management. Susan admitted that she tended to '*steal*' autonomy after experiencing an '*annoying and frustrated day'*.' Her negatives feelings triggered her actions, which were not only taken to benefit service-users but were done to boost her own well-being. It is possible that she was able to '*feel better about work'* because her actions were more client-centred, i.e., were aligned to a value she held.

"…so the autonomy I have is – basically I have none about when I see people, although I take some… I've just moved a child on to that pathway without telling anybody – because he's not diagnosed [laughs] um, but he just needs to be on it… I know and his mum knows and no-one else knows I'm doing it [laughs] so there's that. There's kind of like 'stolen autonomy' but I just do it to make myself feel better about work, and I do it, yeah, if I'm particularly annoyed, had a particularly annoying and frustrated day, then I do something extra for somebody – like, in a kind of stolen autonomous way." (Susan, NHS)

"I'm so glad that (this survey) is anonymous because I block off more admin time than I'm supposed to [laughs]. Um, but I'll tell you what's awful. I think probably, I think my manager knows I block out more admin time than I'm supposed to…" (Susan, NHS)

Susan's account also revealed that the motivation for some of her actions was the alleviation of her guilt. She accepted some culpability for not meeting the needs of service-users and admitted that there was a personal gain in terms of her well-being, in choosing to be involved in extra projects – again, she wanted to feel better.

“Um, but then I know that I’m also working on the improvement project and I’m trying different things and I’m pushing really hard… I feel guilty about how little I’m already providing and so then, because of that guilt, like it’s really assuaged if I say yes to something extra. I feel a bit less guilty... everything I do that feels like extra that I shouldn’t have time for, those are the things that make me feel better. ‘Cos I feel guilty, I feel frustrated that, oh the package is so small, they’re not meeting people’s needs – to make it better, that’s for me. I think I do that because it makes me feel better about my job.” (Susan, NHS)

In contrast, Alice appeared to have autonomy over her caseload. However, she described the control that she had as being unsanctioned – she was reprimanded for managing her caseload in the way that she thought was appropriate.

“I think I had complete autonomy actually. Apart from the fact I would manage it as I saw fit and then get told off for not seeing enough patients.” (Alice, ex-NHS)

Only Pamela’s account depicted a course of action that reflected an attempt to change the status quo through legitimate means. However, even for her, this was not straightforward, involving what she saw as risk resulting from making her thoughts and suggestions public within the service, and carrying a substantial emotional load for her.

*“I have just managed to change a pathway. To reduce a waiting list that’s gone from months now, to weeks. Just by writing to the right person on an email and copying it to everyone. I took the risk, I thought, ‘I’m gonna get slammed for this, but you know, it’s worth it because we cannot have another person die while they’re waiting for this investigation.’ But isn’t **that** emotional?” (Pamela, NHS)*

9.5.2 Taking control by leaving one’s job.

Five participants chose to leave their jobs, and one considered leaving, as a strategy to provide them with the control that they felt was necessary to be able to practice in a way that was consistent with their beliefs. Susan’s need to restore her own well-being, seen previously, had possible consequences beyond the attempt to change the situation at work. When contemplating reducing her hours in the NHS, she acknowledged her own

need for '*fulfilling relationships'* with service-users; a key component of 'being' a therapist, identified in subtheme 1a.

> *"I've considered reducing to part-time in the NHS and doing part-time private work, just so that I could have a longer, more fulfilling relationship with a family. Um, so I thought that that would meet some of my needs for the reasons that I enjoy the job…" (Susan, NHS)*

Alice, like Susan, focused on her own needs. Her account revealed an awareness of the need to take care of her own well-being. Following a period of sick leave to deal with stress, she was prepared to try and work in the NHS but felt that she was unable to meet her health needs there, and she made the decision to leave.

> *"So, after I went back from sick leave I thought I would go back and give it a try and see how I felt and see what the lie of the land was and kind of judge whether I was over it and whether I could just get on with the job. And I went back from sick leave and quite quickly realised that so little had changed that it was going to drag me back down to where I'd been before. Which I didn't want to do. So, at that point I decided that I was going to set up independently and see where that took me." (Alice, ex-NHS)*

Willow focussed not on her own needs, but on the needs of service-users. Her account contained details regarding her feelings of dissatisfaction due to diminishing autonomy, described above. She again referred to this when discussing her decision to leave the NHS. The language Willow used when discussing her move was strong: the phrases '*dead against'* and '*reluctantly felt forced'* indicated that she experienced some conflict when considering transferring to the independent sector. Willow's move was in opposition to what she believed (the right to access free healthcare), but she was able to make the choice by relinquishing some responsibility for that decision, stating that her patients provided the justification for making the change. Despite discussing the frustration around being unable to do the job as she felt it should be done, she did not claim that the primary rationale for leaving was her decision to fulfil her own needs. She transferred some responsibility for the decision to service-users, by framing her decision within the context of their needs, which enabled her to defend that decision.

“I very reluctantly felt forced [pauses]. I really didn’t want to go into independent practice because I’m a really massive believer in the NHS and I don’t like private health care. I’m dead against it. But, simultaneously, because (the AAC) service was being cut down, and then I was also working in an aphasia service and that was being cut down as well, patients started coming to me and saying, ‘Do you do private therapy?’ And I said, ‘No. No, I don’t. I’m sorry. You could try going to ASLTIP.’ And then, a couple of years, a couple of people said to me, ‘Do you provide private therapy?’ and I said, ‘No.’ And they said, ‘Can I ask why?’ and I said, ‘Well, it’s against my principles.’ And it was really interesting, because it was about three people who said, ‘Well your principles are all very well, but we don’t have speech therapy.’ And so I think because it came from ***them****, because it came from patients saying, ‘Your principles are all fine and dandy, we’ve been stuck here, you know, on the AAC side of things for 3 sessions, or the aphasia, you know with 8 sessions, and now – we’re on our own.’ So I thought, ‘Ahh, okay, maybe I could justify it then,’ [tone in which this is said indicates some discomfort with the statement] and so, um, and that’s when I thought, ‘Okay, I’ll do, the two things (NHS and independent work) together, and see how it goes. And see how I feel about doing independent therapy.’” (Willow, SE)*

9.5.3 Achieving control as a self-employed SLT: Driving my own boat.

“I’m driving my own boat. If I’m, if I, if that’s what I think is important to be done, then I’ll do it. I’m not doing it because somebody else has told me that that’s what I’ve got to do [laughs]” (Willow, SE)

As seen in the previous section, some participants considered leaving the NHS and moving to the independent sector (i.e., becoming self-employed) to enable them to take back control over how a service is delivered. For those who did make the move, this strategy appeared to be effective, the experience of being self-employed was characterised by increased autonomy. The freedom to exercise choice was demonstrated by Ruby and Lesley, who like Willow, both discussed control in terms of clinical decisions they made, particularly including dosage.

“…if I perceive a need and if I feel that there’s actually a way that I can actually support a child to make gains, and if their family are happy to fund that, then we can make it happen. So there isn’t anybody externally, telling me that they’ve had their allotted allowance and whether I see a need and could actually see a way of actually improving their lot, you know,

that's irrelevant, they've had their bit. So that doesn't exist so that's actually, you know, there is more clinical autonomy… and so the kind of progress you see is – that I see – has been, you know, quite a different experience in lots of ways, which has been really refreshing." (Ruby, SE)

"I can't help but make a comparison to the NHS. Just because it's two very different ways of working – um, I'm totally in control of any recommendations I make; they are not resource-driven (in terms of my service). So if I feel a child needs ongoing intervention, for me to be able to deliver my service in the best possible way; that is what I will recommend. And obviously, based on resources – the client's resources – financially, um, if they are able to fund it, then we have no barriers in terms of, we can only deliver a short period of intervention." (Lesley, SE)

Lesley and Ruby also both described a broader level of control, referring to caseload management and the lack of '*internal politics*':

"And I would say, going to regular meetings with (self-employed) colleagues, there are a lot of people that are, to me, seem really happy. They've got that balance right, they're doing as much or as little as they want to do, and they're in control. And, I mean, I am aware, I am in control. And that's why earlier I said, 'When I do get overwhelmed, it's self-inflicted.' I think. Because I can control that." (Lesley, SE)

"And I think back to the other elements of autonomy… I genuinely enjoy not being locked into a system that has its own internal politics going on..." (Ruby, SE)

Becoming self-employed did not, however, entirely avoid conflict. The conflict present while an employee – due to a lack of control over the way a service was delivered – appeared to be removed, as seen in the previous section. However, those who moved to the independent sector experienced conflict because their actions were – once more – not aligned to their values. Believing in the ability to access healthcare regardless of financial position was discussed in subtheme 1b – conflict for self-employed SLTs was typically expressed as concern that their actions were not consistent with this belief. Alice had not yet started working for herself when interviewed; she attempted to alleviate feelings of conflict by considering possible benefits of the privatisation of healthcare, but she did not appear to be wholly convinced by the argument she described.

“…obviously the downside of the private work is that you’re only going to get the people who can afford to pay for it. Which is sad because it puts you in the class system again, if you like. If you’ve got it and you can pay for it then you’re alright. If you haven’t and you can’t, it’s a bit like America, isn’t it, really? In, in some respects.” (Alice, ex-NHS)

“I think it’s a different way of thinking. But somebody said to me a long time ago, if the people who can pay do pay, does it take some of the burden off the NHS? And then free up some time for the people that can’t pay. Maybe it does, I don’t know. I don’t know.” (Alice, ex-NHS)

Willow and Sally’s accounts also alluded to their belief that healthcare should be freely available to all. In addition, Sally explained the duty that she felt to the NHS, having gained the skills she has while working there – she questioned whether her decision to charge for services was ethical, and her repetition of feeling ‘*bad*’ and ‘*terrible*’ suggested that she really struggled with this aspect of being self-employed.

“I hate asking people for money” (Willow, SE)

“…morally, it felt wrong because I feel that the NHS is the service that everybody can have, and it’s bad that I’m keeping everything, all the skills that I’ve gained, and my expertise, which has been honed in the NHS, under other NHS therapists. And I’m taking that away now from my local area. Um, it felt really bad. Um, and I felt bad that only people who are well off enough can afford that now. Do you know what I mean?... I felt really terrible about it. [laughs]” (Sally, SE)

Self-employed participants also described a number of different ways in which they were able to resolve the conflict that they experienced due to a disconnect between their actions and their beliefs. Some focused on how their actions were now aligned with a different value – the ability to affect change. Like Sally, Willow discussed ethical concerns regarding working privately – but seeing that she could affect change allowed her to feel comfortable with her decision.

"So, then I had a massive ethical dilemma about, I'm now contributing to the problem, because, you know, if I now go into the private health care realm, then, yeah, so for me it was ethically really difficulty. But once I started working as an independent, and could see what I could do, um, I thought, ah, no, this is, no, it's – I'm okay about this." (Willow, SE)

Self-employed participants also referred specifically to the financial elements of being self-employed – changing their behaviours to match their values. They engaged in non-charged for actions, bringing their behaviours closer to their values around universal healthcare, thus minimising the conflict they felt.

"And I think maybe that's also why I give away a lot, why I sit on a lot of committees, and I do a lot of free work, because that sits better with my conscience [laughing]" (Willow, SE)

"…this definitely comes into the well-being thing…I actually struggle with the fact that I charge people for my services…I never charge people for the full amount of time. I always give people more time… So, I think that's part of who I am, possibly a lot of speech and language therapists struggle with this – it's a helping profession (but) people are paying me…" (Lesley, SE)

9.6 Summary

In both sub-groups within this sample – those who were employed and those who were self-employed – there appeared to be a mismatch between beliefs or values and behaviours, resulting in conflict. This study has established that for SLTs, affecting change and building therapeutic relationships are important values. As employees, the clinical actions or behaviours of an SLT – determined by service constraints – were not necessarily in line with these values. Some employed participants sought to gain control through unsanctioned measures, hinting at a degree of deception by the SLTs. Others left the NHS, and sometimes the career. Self-employed SLTs had better control in their jobs. However, a further value articulated by participants was that support for communication is a right and should be available to all, regardless of financial status. The move to self-employment was not aligned to this value, resulting in further conflict. However, self-employed SLTs strove to overcome this conflict; both by making behavioural changes and by shifting their focus from speech and language therapy being available to all, to being able to effect change – another important value for SLTs.

CHAPTER TEN: SUPERORDINATE THEME FIVE
LOOKING AFTER WELL-BEING – SUCCESS AND CHALLENGES

10.1 Overview of Superordinate Theme Five

This theme describes how participants looked after their well-being, and how this could be successful, but that there were associated challenges with self-care. The subthemes expand on how SLTs took responsibility for their well-being, making both behavioural and psychological adaptations to their working lives in attempts to safeguard their health. Their efforts included using resilience to manage challenges, although personal resilience could not be relied upon to ensure well-being. If demand outweighed capacity in an ongoing way, then resilience may have, at times, failed to protect against distress because personal resources were depleted. The effects of stress for SLTs were numerous and included anxiety and worry, sleeplessness and fatigue.

Superordinate Theme Five	Subthemes
Theme Five: Looking after well-being: success and challenges	5a: Taking responsibility for well-being 5b: Personal resilience to support well-being 5c: Stress and its consequences

10.2 Subtheme 5a: Taking Responsibility for Well-being

"I'm very passionate about the fact that you need to look after yourself in order to do a good job – and I think lots of people in the health professions generally don't take that into consideration a lot of the time and will over-work for the benefit of their patients, which is, you know… because that's why we're in a health profession, because we care about other people. But, yeah, I just think it's really important to look after yourself." (Jan, NHS)

Jan's comments captured a core tension that characterised the experience of most of the SLTs in this study – that of needing to balance one's own well-being, with feeling responsible for the well-being of service-users – in 'caring' for them. Her comment about caring is linked to subtheme 1b, 'Values and beliefs' which discussed the motivation to be of service. Sally echoed Jan's suspicion that health professionals might not prioritise their own well-being when describing her ASLTIP supervision group members.

"And (clinical support/advice) is I think, for all my colleagues, their number one priority over and above their own well-being." (Sally, SE)

However, some SLTs in this study successfully took care of their own well-being, and several discussed self-care strategies that they implemented at work. Jan looked after herself by adapting her behaviours (i.e., the way she worked) to the demands of the workplace as well as by managing work-life boundaries, demonstrating agency with regards to her well-being.

"And being able to sort of adapt how you're working to try and (manage pressure) and try and reduce that stress on yourself as much as you can. Um, yeah. So you have to be flexible, I think…" (Jan, NHS)

"Um, so, I try to be really aware of my well-being and think, 'Okay, if I've worked over some hours,' I think, 'Right, I'm gonna make sure I take those back.'" (Jan, NHS)

Other participants also described practical measures aimed at managing excessive demands that might threaten their well-being. Emerging from Alice's account was a perception that these efforts were sometimes futile in the face of ongoing issues at work. She described a situation where there were various demands being made in terms of targets for seeing clients, managing a colleague whose competence was being questioned, and supporting other SLTs in the team. Notwithstanding her '*best efforts*', including attempting to garner support, there is a sense that she was powerless, and the situation resulted in her being signed off work for stress.

"I was trying to keep control of things… So, [sighs] so that went on and on and on despite best efforts to manage it, trying to put things in to place, trying to get other people to support, trying to get them to think things through for themselves, etc. etc. All (those demands were) going on, on a daily basis." (Alice, ex-NHS)

Evident from some participant's accounts was that taking responsibility for their well-being included obtaining support from others. However, tied to this was a feeling that seeking support was not a viable strategy. Anne's account alluded to stress being an accepted element of working in the NHS, furthering the impression that SLTs might view seeking help as fruitless.

Anne: I can go and contact Occupational Health, but you know…I'm not going to do that, am I?

Claire: I hear what you're saying, can you tell me a little bit about that feeling, 'I'm not going to do that,'?

Anne: What should I tell them? 'I'm stressed in my job.' I work in the NHS, I mean, come on, everybody's stressed in their job. [laughs]

This feeling that seeking support would be ineffectual, or that asking for help was not encouraged, resulted in SLTs feeling that they were unsupported by their employers, as Pamela and Lesley's accounts suggested. The responsibility for their well-being was then transferred entirely to the individual, as seen in Isabella's comments.

"I think you're expected to cope until you can't. I think that's the case." (Pamela, NHS)

"And you have to deal with your stress and get on with it." (Lesley, SE, discussing working in the NHS)

"I don't know, maybe if you have your own strategies for well-being, maybe, and, yeah, finding out what it is that you need to do." (Isabella, SE, discussing working in the NHS)

In addition to practical measures, some described psychological adaptations at work, to support their own well-being. Both Gwenneth and Jan made conscious attempts to improve their psychological responses to work by striving not to feel overwhelmed by their workloads.

"…sometimes it's hard to switch off… So, since the New Year, I've been working on – em – really thinking about priorities and what needs to be done this week and not, 'Oh my goodness, I've got this huge list of things that I need to do.'" (Gwenneth, NHS)

"Um, I try to sort of rationalise as well, if I'm panicking, thinking, 'Oh God, I haven't finished this yet.' And just thinking, 'It's fine. I've got a week to do that.' Like, 'I don't have to do that today, or tomorrow. That can actually wait.' So, trying to like calm myself down and rationalise a little bit. Um. Yeah. Put it into perspective a little bit." (Jan, NHS)

Others employed self-care strategies outside of work. These strategies included both physical activities and efforts at managing thoughts and emotions. The accounts of some indicated that they usually incorporated well-being strategies into their daily lives – while Susan described '*planning*' for well-being, she went on to discuss what happens when she stops cooking a healthy meal, exercising etc. It therefore became clear that taking responsibility for her well-being went further than planning – she included health activities as part of her daily life. For others, focusing on well-being came as a reaction to having been unwell. Hendre's strategy to manage her psychological well-being, following being signed off work for stress, was successful. Her description provides insight into the dramatic effect it had on her life when she says it '*saved me'*. None of the participants mentioned being engaged in social activities as part of looking after themselves.

> *"I use an app on my phone to track my mood and my energy level… I really feel like well-being is something that I have to plan for, a lot in my life. I have to really think about, like when am I going to eat? When am I going to exercise? How much sleep am I getting?" (Susan, NHS)*
>
> *"I do Pilates. I try. Um, and I walk." (Lesley, SE)*
>
> *"But what I did, was the mindfulness course. That sort of saved me. I needed that time away, just to get that perspective…" (Hendre, NHS)*

Being accountable for well-being included an acknowledgement by participants that some of their stress is self-imposed. However, this acknowledgement is contextualised within factors over which SLTs arguably did not have control – a lack of time to process thoughts and emotions, and unmanageable caseloads. Pamela's phrase, '*kicks me in the backside'* alludes to her feeling that her inability to take responsibility for workload management lead to unpleasant consequences.

> *"And I think some of that's self-imposed stress, if you don't feel like you're doing what you should be doing for somebody, but you haven't actually got time to stop and think about that." (Alice, ex-NHS)*
>
> *"I was putting a lot of pressure on myself. But again, big caseloads." (Isabella, SE)*

"And that I was taking on too much. Um, that still kicks me in the backside sometimes…" (Pamela, NHS)

Following on from the concept that stress is self-imposed, participants in this study also demonstrated awareness that individual differences could contribute to stress. Jo reflected on how personality might interact with the psychosocial environment of a job. Jan took ownership over feeling '*anxious*' but also acknowledged that there were pressures in the job, and that she was not alone in experiencing these.

"I think so much depends on personality, career, life stage. Um, you know, I've got one colleague who is as laid back as they come and, God, you need her around. Um, you know, but she won't be the one that affects change…Another colleague is, yeah, at times, extremely stressed. Again, that's partly what she brings with her, um, but she's working with very – there's a formal name for it, I've forgotten what it is now – but, you know, it's a high-demand, low-support sort of model." (Jo, NHS)

"I can be quite an anxious person… also dealing with like being under pressure as well. Um, because yeah. I think we're all feeling it at the moment…" (Jan, NHS)

Interwoven with taking ownership for their responses, was an awareness that 'fault' for failing to manage might not actually lie with the individual, but that the demands of the job might be unreasonable for all. This was elucidated in Willow's account. Her comments suggested that SLTs generally don't admit to struggling when she described how she thought that others were coping but then contradicted this, stating '*Of course they're not, but you think they are*.'

"…you think, 'I've got to work within these parameters, so it must be me. How, how can I, you know? Other people are managing it,' Of course they're not, but you think they are. You know, so, so, so I, you know, how could I, how could I deliver what I would normally deliver in 18 weeks in 3 sessions? Come on. 'Be creative! You can find a way!' You know. [laughs]" (Willow, SE)

Lesley's account expanded Willow's point – the notion that other people were not managing was inherent across the profession, it was '*typical*' to feel stressed. However, for Lesley, personality – and the possibility that all SLTs possess similar individual factors – played a role in the relationship between the job and stress.

"So, I think, just taking a step back – it's typical to feel stressed. I think part of that may be about the kind of people that are speech and language therapists – it's about our personalities, um, on the whole." (Lesley, SE)

10.3 Subtheme 5b: Resilience

The concept of 'resilience' was raised by nine participants, eight of whom were organizationally employed. Resilience was acknowledged as a necessary attribute, to do the job and to maintain well-being, but it was felt that this need only became clear post-qualification. Jo's mention of survival and continuing to go on provides some initial insight into the possibility that for SLTs, resilience was necessary as a response to a chronic situation as opposed to as a response to isolated events.

"I think you need to be a lot tougher and more resilient and that was not, not on my application. [laughs] I don't think it was expected to be. Just to survive actually, and just to continue…" (Jo, NHS)

Although acknowledging that resilience was necessary for SLTs, participants felt that it is a concept that – while currently very much in focus – was poorly understood by people generally. Some participants defined resilience by what it is *not*: '*a bit of mindfulness'* (Kathryn) or '*putting up with it'* (Jo). Instead, the meaning of resilience for SLTs included coping. Kathryn's comment, '*Cos that's an insult, isn't it*?' suggests that she feels patronised by current perceptions of resilience. Jo's account evokes an image of someone who is calm in the midst of disorder and unpredictability. Her phrase, '*centred within the chaos*' was arresting and for her, being resilient meant not disintegrating.

"I think (resilience) is a word that's being thrown around at the moment…we need some strategies so that when you feel bad you kind of have a coping mechanism and it's about building up resilience but by that I don't mean just going and doing a bit of mindfulness. 'Cos that's an insult, isn't it?" (Kathryn, social enterprise)

"I remember being horrified when this friend who's left the NHS said how the trust was using the term, 'mental toughness', you know, which is sort of rather like the army or something, and this, as he said, just 'Getting on with it,' and 'Putting up with it.' Whereas I suppose I think of emotional resilience, you know, you're, you're very cognisant that this is not okay, but you're, you're able to be sort of centred within the chaos to, to help facilitate change. So, it doesn't mean 'just putting up with it', or just being okay. But it means not crumbling so that you can achieve change. I suppose." (Jo, NHS)

Participants in this study felt that they were resilient in their jobs. However, there was evidence that resilience is complex. For Alice, resilience was not constant; there were times when resilience failed to protect against distress because environmental demands outweighed her capacity to summon her resources in order to adapt to, or cope with the stressors she faced.

"And I knew (reaching the point where I would be signed off work) was coming. And I knew I was getting to that point, but I'm quite a tough, resilient person. And it does take a lot to get me – it did take a lot to get me to that point." (Alice, ex-NHS)

Anne's account also suggested a working environment where her resilience was only able to guard against stress to a certain point, after which the demands outweighed her capacity to rebound. She described how she '*can overreact*' to '*something fairly small*'. At first reading, this might suggest that Anne lacked resilience. However, seen in the context of her account of the everyday stressors in the working environment, further scrutiny revealed that the demands Anne faced were relentless – linking to subtheme 2a, 'Daily working life: too much to do'. This resulted in her constant '*heightened state of stress and anxiety*'. There was an implication that she was permanently confronted with situations that required ongoing resilience – it was not the case that she was not resilient, but that there were times when her resilience failed her.

"I've got constantly a heightened state of stress and anxiety… so something fairly small can happen and I can overreact and, you know, find it really difficult, I mean. You know, I can certainly recall times when I've been in the office trying to do something and I've just thought 'I'm going to have to go away now.' There was one recently, I'm trying to think what happened. Can't remember. Um, I really can't remember, I just remember that there

must have been a lot of things going on and, um, maybe a few things went wrong, I'm not sure, and I was in the office and I just thought, 'I'm just going to have to go away to the toilets now, because I'm super-stressed out, and I cannot cope,'…" (Anne, NHS)

The feeling of working at the edge of one's capacity for resilience that is suggested above, was further illuminated by other participants. Hendre described a feeling of having had as much as she could bear, without receiving support. Jo spoke of the accumulative effect of being overburdened, which resulted in seemingly small issues precipitating a failure to cope. It is possible that employing coping strategies on an ongoing basis because the job demands are unremitting, means that resilience is compromised in the face of events which would otherwise be manageable, but then act as catalysts for more severe stress reactions.

"I'm up to here [gestures to the top of her forehead] and nobody's helping me." (Hendre, NHS)

"…it's a bit like the straw that breaks the camel's back, isn't it? If you're already stressed, And you're doing a bloody hard job" (Jo, NHS)

Others viewed resilience more broadly. Jo mentioned organizational resilience – the team having the ability to respond and adapt to changes (she had been discussing staffing issues). Susan also viewed the concept as incorporating more than personal resilience; to include her professional network. Her question, '*am I **well enough** to cope?*' (bold added for emphasis) and her subsequent inclusion of '*energy levels'* acknowledge the complexity of resilience, that being resilient draws on energy, and on an adequate 'level' of well-being. Susan's phrase, '*knowing how I can get back to myself*' alludes to stress causing a temporary uncertainty in Susan's sense of who she is, resilience allows her to maintain her equilibrium, to return to her sense of self.

"…we haven't touched on recruitment, which, that's been a massive issue… my manager started to talk of it as well. Having some resilience in the team, you've got a big enough critical mass." (Jo, NHS)

"I think of well-being as, like in a resilience-based way. Like, um, like well-being as, like when things are challenging, like how, like am I well enough to cope with it? Um, do I have the right people around me? Am I in the right support network? Um, like am I kind of like emotionally resilient enough myself, and how's my energy level going, that's really important." (Susan, NHS)

"…the reason that like I would immediately announce if I'm stressed is because I want people to help me. I don't want people to like just give me some space, and, like support and [pauses] like because my aim is to very quickly not be stressed any more…Um, (resilience) means, to me it means [pauses] it's to do with knowing how I can get back to myself. Like, having like a base of feeling okay, and that I don't stay in it all the time, but the more resilient I feel, the more I know I can quickly get back to that base that I want to be at…I do it in my network of people. Yeah." (Susan, NHS)

There was an understanding that in order to employ strategies that fostered resilience – such as reflection – one required time in which to do so. As a self-employed SLT, Lesley was able to create the time necessary. In contrast, in the NHS, Susan sometimes found it difficult to build in time in which to process an experience. Her account suggested that not having processing time would leave her holding the stress from that experience.

"I've had situations that have been very stressful. And I've needed some recovery time from them… And, by a recovery period I mean it might have been something like just a week away from that particular situation, to just think about it." (Lesley, SE)

"And I can (recover) quickly, but I need 5 minutes. I walk around the building, have a drink of water, like just let all that feeling out, but like increasingly there's less and less time. [pauses] Yeah, and I feel like if I don't immediately like go over it, then I keep it for a long time." (Susan, NHS)

For others, the need for resilience became redundant – their focus shifted to thoughts regarding the impact that unremitting pressure had on them in terms of their professional practice, and this caused them to consider their longevity in their current jobs. This was explained succinctly by Jo.

"I think it's more, it's more of a grind, I think, a long, over time, and I would say, it's a case for me, of you know, how long do I want to tolerate this big compromise for my professional practice if things don't change." (Jo, NHS)

Personal resilience was acknowledged by SLTs in this study to be a vital quality at work and one which they were required to draw on routinely. However, there was a sense that this was not enough to ensure well-being. The reasons for this could include that demands might, at times, outstrip an individual's capacity for personal resilience and that personal resilience could not operate in a vacuum – organizational resilience was important, and the support of others had a role to play in enabling individuals to implement adaptive behaviours that allowed them to respond to particular stressors. As was seen in the previous subthemes that considered the backdrop in which personal resilience operated (i.e., having too much to do at work [2a] and lacking support [3d]), ecological resilience was not always robust. Consequences of the erosive nature of chronic stress will be addressed in the next subtheme.

10.4 Subtheme 5c: Feeling Stressed and its Consequences

Participants in this study demonstrated some understanding of stress as a construct - there was recognition that stress is not necessarily negative, but that when demands exceed the resources that individuals have, then well-being is endangered, as described by Carol.

"You need a certain amount of stress to keep you going. It's when you either push yourself too much or you feel as if the service you work for is expecting an unreasonable amount of work or effort or success from you, I think that's when the stress tips over into becoming too difficult… I really was struggling with the stress of being a speech and language therapist working in a busy hospital setting." (Carol, ex-NHS, ex-SLT)

Further evidence for how participants understood their well-being was in their feeling that personal lives and occupational lives were not wholly distinct from one another. Susan felt that occupational well-being could not be separated from well-being generally, and Gwenneth acknowledged how the two different domains – work and home – may influence each other.

"…my well-being at work is my well-being." (Susan, NHS)

"I know that stress has affected me. I can see it affecting other people. And, um, I know that home life is an aspect of how well we manage our work situation, but there are things in work that also affect how we cope and how we manage home situations" (Gwenneth, ex-NHS)

Participants' comments about stress should therefore be viewed within the context of their understanding of the construct, which added nuance to their interpretations of their everyday experiences. All the organizationally employed SLTs used the word 'stress' to describe how their jobs made them felt. All those who were self-employed also described feeling stressed when they had been working in the NHS, and four of the five mentioned stress that resulted from working independently. Some, like Jo and Pamela, described how stress was intrinsic to the profession and present throughout a career in SLT. Ruby's account added to this, explaining how stress could lead to querying whether one's career choice had been good.

"…it is inherently stressful." (Jo, NHS)

"So I think I was stressed right from the word go…" (Pamela, NHS)

"At times it's been really stressful, and I have questioned whether it's the right thing for me." (Ruby, SE)

Lesley's account provided further insight into the feelings that stress was ever-present, however her interpretation of her experience acknowledged that stress was not exclusive to SLTs but was a characteristic of the broader culture of working in the NHS. For her, this contrasted with working outside of the NHS (this will be further explored in the next section). Lesley's comments also linked this subtheme to superordinate theme four, 'Feeling conflicted, being in control.'

*"… coming in (to the NHS), it was, I was **immediately** immersed in that culture of, 'We're over-worked, our caseloads are insane, everybody's stressed. You just, you have to get on with it. …you have to deal with your stress and get on with it. So, I do think it's, it's part of the culture. But not necessarily in the independent sector. So, I think I've seen a different – I think people are far more in control of their well-being and their stress levels" (Lesley, SE)*

Susan's experience was that while stress may be pervasive, it might not appear to be so. The reason for this might be due to people's unwillingness to admit to stress, as they feared that doing so would be equated with being incompetent. Her comments link to those previously made by Willow, when she discussed other people managing ('*except that they're not*'). This potentially masked the stress that exists within the profession.

"Like everyone I know finds the job horribly stressful". (Susan, NHS)

"…people worry that they're going to be seen as less competent. Then they don't want to say, 'I feel stressed,' because they think it's going to sound like they're saying, 'I can't do this,' which, like, I don't think it sounds like that, but I can see why they would think that was a risk." (Susan, NHS)

There was evidence that SLTs felt that they should not be stressed in their jobs. Kathryn felt that she was '*moaning about nothing'*. While initial consideration of this statement might suggest that the demands she faced were insignificant, this would belie her descriptions of those demands elsewhere in her account. Instead, her feelings might be interpreted as reflecting a situation where the demands she faced were no different to anyone else's. Kathryn demonstrated some resignation regarding the job being inherently stressful.

"Sometimes I feel as though I'm moaning about nothing, but I think it's all – you know – within the context of your job." (Kathryn, social enterprise)

Several physical and mental manifestations of stress for the SLTs in this study were identified. Anxiety or worry was mentioned by six of the ten participants who were organizationally employed. These feelings were discussed alongside other reactions such as unhappiness and feeling alone. Changes in mood, and the impact that this had on families was also described.

“I remember it really affected me physically with anxiety, I had physical symptoms of anxiety – um. And I’d go to work, and everyone would go off and have lunch and I’d feel really miserable…” (Kathryn, social enterprise)

“I become very moody, I tend to take that out on my family, which I hate.” (Lesley, SE)

“Um, as well as, you go home and you’re awake at night and you’re tired and angry and frustrated, so you’re cross with everybody at home. You know, the effects are massive, aren’t they, when you’re in that sort of situation?” (Hendre, NHS)

Half of those who were employed mentioned a lack of sleep. Several also mentioned rumination – ‘*thoughts churning round*’, ‘*all running around in my head*’, ‘*keeps going round in my head*’.

“Sleep. Um, sort of, not waking up early. Often, I think, having thoughts about work churning around.” (Jo, NHS)

“I don’t think my sleep’s as good as it used to be… it was just all running round in my head so I am aware that sometimes it’s hard to switch off...” (Gwenneth, NHS)

“I keep thinking about it, keeps going round in my head”. (Jan, NHS)

“I wasn’t sleeping. I was trying to write up notes in the middle of the night because I didn’t get time to write them because of the travel. Um, I was worried that I wasn’t doing a good enough job for my patients so a lot of sleepless nights...” (Hendre, NHS)

*“I remembered, ‘Oh, I didn’t (call the patient).’ I thought, ‘Oh, maybe I, maybe – you know, maybe I should ring someone (the next) morning (on her day off) and I’ve only just remembered. And I thought, ‘**Actually**?’ But **that’s** stress. Eleven o’clock at night – **‘I haven’t done that**!’” (Kathryn, social enterprise)*

“But (the complexity of a current case) was something that I found quite hard to shut off. And I was still very stressed by the, in the evenings and, worrying about it” (Jan, NHS)

Descriptions of the physical effects that the SLTs' work was having on them included crying. Kathryn described a period at work where she cried every day. She expanded on this, providing a specific example that illustrated how the levels of tension that she was experiencing meant that something relatively small resulted in her crying – echoing earlier descriptions of an overburdened system. That she was crying was dismissed by the person with whom she was interacting – and whose role was to support staff – because Kathryn's response was not unique, it appeared to be the norm. This effectively invalidated Kathryn's response.

"I think I spent every day in tears at some point." (Kathryn, social enterprise).

"I think I came in at the end of one of these sessions (support set up in response to feedback indicating high dissatisfaction among staff) and it was two o' clock 'cos I hadn't had my lunch 'cos I'd gone out to do a lunchtime assessment, which is another thing that speech therapists have to do – and I couldn't find a parking space and was really stressed and I just burst into tears on one of these people and she said, "Oh, don't worry, you're about the tenth person that's cried. [laughs]" (Kathryn, social enterprise)

Other accounts of the physical effects of the job included feelings of nausea, headaches, poor concentration, and general feelings of pain. These are clearly described in the accounts of Hendre, Jan, Alice, Pamela.

"… Again, going in to work, nauseous. Yeah I think a lot of us have felt that nauseous feeling about going in to work, you know – it's the reaction to that stressful situation that we're in all the time." (Hendre, NHS)

"I, I felt very stressed, I was crying a lot, I was coming home and crying a lot. Um, things like poor concentration, struggling to maintain sort of concentration and energy levels through the day when I was at work. That kind of thing – very easily upset by things, very short fuse, lack of patience. That, that kind of thing. (Alice, ex-NHS)

*"Yeah, it is a physical, I've had definite physical, I've had a lot of physical symptoms over the years as well, from stress. Migraine, back-ache, palpitations, breathing, you know – not breathing correctly, just pain. Actually. **Pain**. Physical aches and pains." (Pamela, NHS)*

"Definitely had headaches. Yeah, and crying. [laughs]" (Jan, NHS)

For Jan, '*tension headaches'* were linked to feeling '*panicky*'; although she described being able to self-monitor and '*step back'*. The level of Isabella's stress, however, reached a point where she was no longer able to cope. She mentioned '*going over the edge'* which meant she was no longer able to do the job she was doing. As a self-employed SLT, she was able to stop working in the one school that she identified was causing her most stress.

"I get very, very tense. Like physically. Um, and I always get tension headaches. Um, when I feel stressed. So, yeah, I know that I need to take a step back if I've got a headache. Um, [exhales] I get quite, generally, quite just like panicky." (Jan, NHS)

"…every night before I would go into that school, I would almost have a panic attack, and not sleep. [laughs] I can't remember when you did the survey, but I think it was around about – and I was still thinking like, 'Well, my gosh, I'm about to go over the edge.' So, yeah, I did eventually. Yeah, so that I wasn't able to do that job…" (Isabella, SE)

Two of the self-employed SLTs discussed stress impacting on the effectiveness of their immune systems, with Isabella discussing the links to mental health and Ruby's account reflecting the inability to bounce back from minor illness.

"…so last year I was sick for most of winter, just had a kind of virus and a doctor wanted to sign me off, she said, 'You know, I just think you're really stressed, you're not sleeping, your body's immune system isn't working properly. You just keep getting every bug that goes around.' Um, so I think physically. But also, yeah mentally, you just kind of feel stressed. So, yeah." (Isabella, SE)

"Um, but what I notice is that if I do get ill or pick up a cold or what have you it will really, really last and it's as if I don't really have the resources to kind of like, to get back on top of some – I don't bounce back that quickly. Um, and I think that if the, the more, the uh, the lower my kind of levels of well-being are, that the more likely that is to happen. It will take me a long time. I would feel run down…" (Ruby, SE)

10.4.1 The daily grind and tipping points.

It has been seen that participant's descriptions of their work experience highlighted how the impact of specific events, and their ability to cope with these, needed to be seen in the context of long-term concerns. Both Alice and Jo used the term '*grind*' to describe the daily toll that they experienced. For many, ongoing work issues provided an underlying landscape upon which particular events played out. These events could result in negative consequences for well-being, and substantial changes to an SLT's life. Ruby described the context of her job that formed the backdrop to what she called her '*tipping point'*, the moment she decided to leave the NHS. Her experience was described in theme four, 'Feeling conflicted, being in control'. Similarly, Alice's '*trigger*' – where she left the NHS – occurred in the context of ongoing stressors. Her animated description – the word '*bang*', accompanied by clapping her hands together, suggested that this was a crisis point for her. She felt she had coped well for a while despite the difficulties presented to her but that ongoing events resulted in her feeling overwhelmed and despondent – her resources that would have enabled her to deal with difficulties had been depleted over time.

"I mean it was, obviously there was, it was accumulative over a long period of time. Um, the end of that sort of cumulative period… So there was (preparing an application for a job I didn't really want), and then at the same time I got my first pay slip with pay protection on it, realised, I mean obviously I knew, but realised, seeing it as clearly as that in black and white, how much per month I was going to be losing. And I think the two things just kind of went 'bang' [claps hands together] and that was, that was the trigger. And I came home that day and couldn't stop crying and thought, 'That's it. I can't go back… I think it was probably, it was cumulative in that everything happening together hit me when I was at a low ebb. And it was just too much. But I think I'd ticked along, probably for – I don't know – two years, more than two years before that, with things being quite difficult." (Alice, ex-NHS)

The narratives of other 'tipping points' in this study shed further light on the effect that the participants' jobs had on them. For Pamela, her response took the form of a '*massive*' panic attack where she could not breathe. Like Ruby and Alice, her response should be seen in the context of a chronic situation at work – Pamela had been shouldering the responsibility for supporting a service-user throughout a particularly complex and ongoing situation, and she hadn't been well for some time.

"…when I got back (from conference) on the Saturday, home, I just – something like flew – hit me. So I had to phone in sick on the Monday and by the Wednesday I'm getting fidgety, thinking, 'I've gotta get back to work, I've gotta get back, I'm missing too much, I'm missing too much, all these families, da da da da…' [takes a deep breath] and I looked at my emails and I had a massive panic attack. I couldn't breathe. I just, I knew what it was and I, and I just, I didn't know what to do and then I thought, 'I know. I have to phone the clinical psychologist at work and just tell her what's just happened to me,' and she just said, 'You're not right. You haven't been right for a long time." (Pamela, NHS)

Similarly, Hendre described a chronic situation of constant pressure that resulted in her experiencing a severe response to a specific event, noteworthy due to her inability to recall what that event had been. In the short term, Hendre was very unwell, she needed to take time off work; the enormity of her despair was evident when she said she could not stop crying for a week. In the long term she felt she had to make changes to her work life – she changed to part time hours. Not only was the impact for Hendre calamitous, she felt that the service for which she worked suffered – they lost the skills and experience that she contributed, and the funding for the two days she no longer worked was withdrawn.

"The pressure is a constant… (A manager) rang me and spoke about something – I can't really remember what it was – and I just found myself crying on the phone. I just broke down in tears... And I said, 'I'm going home now. I can't be in work. I'm going home.' …And that was it. I wasn't back for 6 months. Couldn't stop crying for a week." (Hendre, NHS)

"And they have lost two days of my time, they've lost that money as well 'cos there's been nothing filled in for those two days. The money is gone." (Hendre, NHS)

The effect on Carol of the stress that she experienced was similarly profound. Like Hendre, Carol experienced a devastating reaction to an event that she could not in retrospect identify, and like Hendre, this resulted in her inability to work. Carol's statement that she '*just lost it completely'* summed up her experience of losing control, physiologically and emotionally. She later described being unable to meet colleagues while off sick, even at venues not related to work, and she ultimately left the profession.

"I just lost it. And I was sitting at the desk and I was shaking, and I was crying. [pauses] Yeah, and that was it. And thankfully a colleague was sitting there with me. Um, and she just turned round. She said, 'What's wrong, Carol?' and I went, 'I don't know.' I just couldn't put it into words, but I couldn't do anything. Next thing I know she'd called my boss and he'd come down, um, and I was just a, a, um, I was just a wreck (unintelligible) I was just a wreck. [Tearful]… I was there, and I was coming up with all these reasons why I couldn't go home. You know, 'cos I had this to do and I had that to do and, and like so many people I had such a fantastic team of, um, people working with me at the Child Development Centre, um, you know, that you feel you're letting people down if you're not there. Um, but clearly, I couldn't even send an email. This, this email that I was trying to – I couldn't even find the 'send' button. I just had, I just lost it completely." (Carol, ex-NHS, ex-SLT)

Finally, in addition to triggering significant life changes such as moving from the public to the private sector or leaving the profession, the effect of stress could result in profound changes to the way that some SLTs viewed themselves. Reflecting on how experiencing stress throughout her career had affected her, Pamela felt that she'd needed to rediscover her sense of self.

"I have experienced um quite a – quite a lot of stress during my career actually, from time to time. It's become an issue where I've had to take time off because of it and have had to seek various – um – solutions and interventions and different ways of being." (Pamela, NHS)

10.4.2 Self-employed v employed SLTs: 'Micro-frustrations' and 'mini-burnouts'.

There was a clear contrast between the way distress was described by those who were organizationally employed, and those who were self-employed. It was evident that independent work does result in some frustrations. However, there were apparent differences in the causes of frustration for those who were organizationally employed and those who were self-employed. As previously discussed, the feelings of some employed SLTs appeared to be the result of threats to the self – including their personal values (e.g., the ability to affect change) and their own validation. The vocabulary used by the employed SLTs – '*anxious', 'furious', 'disappointed', 'embarrassed'* – revealed a variety of negative feelings associated with their jobs. The self-employed SLTs, on the other hand, referred

more to frustration caused by specific operational events. These included having to take on the responsibility for running a business alongside providing clinical services, as described by Lesley; or difficulties liaising with other health professionals as experienced by Willow.

“There are definite periods where things frustrate me. I think, maybe what frustrates me is managing everything. I would love to have somebody to do my admin side of things. To do my invoicing… the business element of things. I don’t dislike it all, I just find it’s a drain on my time.” (Lesley, SE)

“I find it frustrating sometimes, um, you know, not being able to liaise, or not being able to liaise very well with the rest of the team.” (Willow, SE)

The accounts of two participants in particular clearly portrayed the differences between the psychological impact of being employed and being self-employed. Susan, an NHS SLT, used the words ‘*mini burnouts’*, while Ruby, a self-employed SLT, referred to her feelings as ‘*micro-frustrations’*. Reflecting on the interviews with both these participants, it is felt that both appeared to think carefully before describing or explaining concepts. Therefore, their choice of vocabulary appeared to be considered. Susan’s ‘*mini burnouts’* suggested a stronger response to her work than Ruby’s ‘*micro frustrations’*, both when considering the meanings of the nouns themselves (*burnout* versus *frustration*), as well as the effect of their modifiers (*mini* versus *micro*).

Susan’s description included feeling angry, exhausted, and detached from her work – some of the hallmarks of burnout. In addition, these feelings happened repeatedly, indicating a chronic situation rather than a single response to an isolated incident. This suggests that rather than being separate, distinct ‘*mini burnouts’*, Susan is in danger of her work having a greater impact on her well-being than might initially be assumed.

Susan:	*And, like (my well-being) is something I really have struggled with, actually. Like I've repeatedly, had kind of mini burnouts. Like, all through training and working.*
Claire:	*Can you tell me more about mini burnouts?*
Susan:	*Like um, yeah, so I guess what I'm referring to is like an experience where I was – work really hard, see as many children as possible, um, stay late, um, and then just feel kind of physical really tired, and also just lose my interest in work. Um, so it's happened a little bit lately, I'm just coming out of it now, where I just – I just get a bit cross with it, or I can't be bothered to come here, and it's rubbish, we've had too many cuts and I don't like it. And, I can see in the way I'm working, is that I lose a little bit of professional curiosity, um, and yeah, I'm just less involved, sort of intellectually and in general. Um, and I think it's not good, I think it's not good for my work when I feel that way because I need that curiosity. (Susan, NHS)*

The language that Ruby, a self-employed SLT, used, contrasted sharply with that of Susan. Ruby described her frustration resulting from an isolated issue (a lack of communication regarding a specific event). Ruby was also clear that she might experience a frustrating day from time to time, but that this was not characteristic of her work as a whole.

"I have micro-frustrations. I roll up at a school, having rushed to get there to find out that the kids have all gone out on a trip and nobody told me. And that kind of thing. So, they're much more, they're again, it breaks everything down into small bits. There's not an overarching frustration – they will be micro-frustrations as part of my day. And yes, I might have a very frustrating day if there's lots of those sorts of small things happening, but that's not actually that often". (Ruby, SE)

10.5 Summary

The participants in this study acknowledged the tension between being responsible for the well-being of service-users and ensuring that they themselves were well. Most SLTs had a sense of agency regarding their well-being and employed behavioural and psychological adaptations, as well as self-care strategies outside of work, in their attempts to safeguard their welfare. However, practical measures to manage excessive demands could, at times, be futile.

Participants knew that resilience was necessary for the work that they do. Despite this, there was a feeling that resilience is poorly understood. Participants felt that being resilient is not the same as being well. For them, resilience was complex – it was not necessarily constant and could, at times, fail to protect against stress. Resilience for SLTs must be seen in the context of jobs that are characterised by unremitting pressure - they are compelled to draw on their resilience in a way that is ongoing, as opposed to as a response to isolated events. To successfully respond to isolated events, SLTs felt that they needed time in which to draw on their skills. Furthermore, they viewed resilience from an ecological rather than individual perspective – organizational resilience and the support of colleagues was seen as important.

The SLTs in this study experienced biological, psychological, and social consequences to the work that they do. Physical responses to the job included fatigue, a lack of sleep, crying and numerous other symptoms such as headaches and nausea. Psychological outcomes were typically stress, anxiety and frustration. There was a clear difference between organisationally employed SLTs and those who are self-employed, with those who were employed describing seemingly more chronic, severe stress that led to deleterious outcomes for some. For most employed SLTs, stress was ever-present, with constant pressure providing a backdrop for specific events which had catastrophic outcomes for some e.g., being signed off work, leaving the NHS, or leaving the profession. Seeking help was perceived to be futile, partly due to stress being an accepted feature of working in the NHS.

CHAPTER ELEVEN: CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

11.1 Overview of the Chapter

To meet the overall aim of the study, examining the well-being of SLTs working clinically in the UK, this chapter first summarises and integrates the findings from both phases of the research. The key quantitative and qualitative results from the previous chapters are discussed in detail with respect to the extant literature, and explanations for findings are proposed. Recommendations for clinical practice, suggestions for future research, and the strengths and limitations of the project, are also presented.

A mixed methods design was employed to fully address the research questions. The nature of the mixed-methods design meant that individual objectives were met through combining quantitative and qualitative results. Consequently, both phases of the research addressed both research questions. Sections in this discussion therefore sometimes address multiple objectives. As a reminder, the research questions and accompanying objectives follow:

Research question 1: What is the occupational well-being of SLTs currently working clinically in the UK?

The objectives relating to question 1 were to:

i. Describe the current psychosocial work environment (operationalised as demand, control and support) of SLTs practising clinically in the UK.
ii. Apply the JDCS model (Karasek, 1979, Johnson & Hall, 1988) to the data, to classify jobs held by participants.
iii. Investigate the meaning that SLTs give to their work experiences and well-being.
iv. Explore the occupational well-being of SLTs, operationalised as job satisfaction.
v. Examine the additive effects of job demands, control and support on job satisfaction.
vi. Establish the interaction effects of job demands, control and support on job satisfaction.
vii. Consider the mediating effect of individual differences on the relationship between the psychosocial work environment and occupational well-being.
viii. Compare the occupational well-being of those who are employed with those who are self-employed and to those who straddle both employment settings.

Research question 2: What is the general biopsychosocial well-being of SLTs in the UK? The objectives relating to question 2 were to:

ix. Describe the general biopsychosocial well-being of SLTs, operationalised as incidence of somatic symptoms, levels of anxiety, depression, and social dysfunction.
x. Compare the general biopsychosocial well-being of those who are employed to those who are self-employed and to those who straddle both employment settings.
xi. Examine the influence of the biopsychosocial work environment on general biopsychosocial well-being.
xii. Examine the additive effects of job demands, control and support on general biopsychosocial well-being.
xiii. Establish the interaction effects of job demands, control and support on general biopsychosocial well-being.
xiv. Explore the factors perceived by SLTs to influence their general biopsychosocial well-being.

11.2 Discussion of Results, and Conclusion

The meaning that SLTs give to their work experiences (Objective iii) served to frame, and will be used to explain, some of the psychological responses to work both identified during the survey and described during interviews. Results from Phase 2 that serve to address this objective are therefore presented first.

11.2.1 Being a speech and language therapist.

Interview data from Phase 2 of this study explored comments made in the open-ended question of the survey, revealing the values and beliefs that many SLTs held. These attitudes encompassed 'being' an SLT and underpinned their daily working lives. Most of the participants interviewed felt that it was important to be of service to others. This was realised as being able to affect change for and with service-users. In addition, providing a service that was patient/client-centred was identified as a core belief. Most participants also believed in the right to access healthcare regardless of financial status. There is a paucity of research investigating the values and beliefs held by practising SLTs. However,

in a survey of 151 SLT students at two universities in the UK and Australia, the most common reasons given for wanting to study SLT were wanting to ‘help people’, and ‘make a difference’ (Whitehouse, Hird & Cocks, 2007). These motivations revealed themes of compassion for others, commitment to the public interest and an altruistic motivation to serve people. In addition, a qualitative study comprising 16 in-depth interviews with SLT students (Byrne, 2007) found that all referred to wanting to help others as being an important reason for choosing the career. The current study added to these findings, demonstrating how, once qualified, SLTs continue to hold these values. Furthermore, the current study revealed that compromising these core values may influence psychological responses to the job, as will be explored in the following sections.

11.2.2 The daily working life of an SLT.

11.2.2.1 Demands experienced by SLTs.

The demand experienced by SLTs in the UK was realised in two distinct ways; by workload demands and emotional demands.

Workload was the single biggest source of stress for SLTs and specifically predicted anxiety in SLTs surveyed in this study. Two thirds (67%) of survey participants stated that they often or always had too much work to do and there was a significant correlation between workload and poor general biopsychosocial well-being. Workload was also the element of work most mentioned by participants in the open-ended question of the survey. The only other UK-based study providing information on SLT workload (Loan-Clarke et al., 2010) reported that around 20% of their participants had excessive workloads. In the decade since that study was conducted, it may be that unmanageable workloads have become more commonplace. Workload as a contributor to stress featured strongly across all the interviewee accounts and participants discussed ‘overwhelming’ and ‘relentless’ workloads and large caseloads, exacerbated by inadequate staffing levels, and the perception that targets were unreachable. This reasonably resulted in them feeling incompetent and inadequate. Feelings of exhaustion expressed by the interviewees added to the quantitative data; the survey identified fatigue as the biggest manifestation of stress. Furthermore, some survey participants engaged in leaveism – they took work home, worked through lunch or worked late in order to cope. However, one of the interviewees mentioned that when she began working in the NHS she was ‘immediately

immersed' in a culture of people feeling that they had unreasonable workloads and 'insane' caseloads. It should therefore be acknowledged that participants' interpretations of their personal experiences might have been formed within a backdrop of a widely adopted narrative within the NHS – that excessive workloads are the norm; reporter bias may therefore have influenced the way that workloads were discussed.

Nevertheless, and similar to previous findings (Blood et al., 2002a; Blood et al., 2002c), contributing to workload were excessive amounts of paperwork, a lack of time in which to complete tasks, and large caseloads. Almost half the participants (46%) felt that the size of their caseload was too big. Feelings that caseloads were too large was also significantly correlated with reported caseload size, revealing that perceptions of a caseload that was unmanageable was expressed by large numbers in practice. This finding, along with eleven of the fifteen interviewees reporting caseload as a contributor to stress, prompted further investigation into caseload sizes and the effect this has on SLT well-being.

The RCSLT does not recommend optimal caseload sizes. However, in the USA, the American Speech-Language-Hearing Association (ASHA) has made considerable efforts to support SLTs through their policies and recommendations around caseload and workload. In 1993, they recommended a maximum caseload size of 40 (Hutchins et al., 2010) for SLTs working in schools – the number that Katz, Maag, Fallon, Blenkarn and Smith (2010) would later identify as being optimal. That recommendation, however, did not stem the rise in caseload sizes, and services in many states used the number as a minimum instead of maximum number (ASHA, 2002). Almost half the SLTs in this study (45%) held caseloads above 40, the number above which Katz et al. (2010) reported that SLTs find their caseloads unmanageable. Of the 45% of the sample with a caseload over 40, the majority (89%) felt that their caseload was too big. When interviewed, all the SLTs employed by the NHS discussed caseload size or large waiting lists as directly and unequivocally contributing to stress. The self-employed, school based SLTs also discussed how caseload size could be problematic for them, if they were committed to providing a service to a particular school and referrals in that school continued to increase. SLT caseload size is arguably an important indicator of workload, because in many cases much of the non-clinical work of an SLT is generated from the clinical caseload that they hold, meaning that an increase in caseload results in an additional increase in related tasks for which SLTs are responsible. The caseload numbers reported might therefore provide compelling evidence for the claim that workloads are unmanageable. These findings align

with previous research that has reported caseload size as being directly associated with stress (Blood, et al., 2002a; Blood, et al., 2002c; Harris, et al., 2009).

Turning to job satisfaction, previous research in the USA has suggested that realistic workloads are predictive of SLT job satisfaction (Smith-Randolph & Johnson, 2005), and that high caseload sizes correlate with dissatisfaction (Blood, et al., 2002b; Hutchins et al., 2010). Although the current study found that SLTs had relatively large caseloads (mean caseload size = 56), demands – including unmanageable workloads and large caseloads – did not make a significant contribution to dissatisfaction for the SLTs. While caseload size has not always previously been found to be predictive of job satisfaction (Kalkhoff & Collins, 2012), the finding that higher caseloads did not make a significant contribution to dissatisfaction was unexpected, as previous research (Blood, et al., 2002b; Cocks & Cruice, 2010; Kaegi et al, 2002, Smith-Randolph and Johnson, 2005) has generally tended to link high caseloads with dissatisfaction. One of the reasons for the current finding may be that the generic metric used to assess satisfaction did not include items specific to SLT jobs, such as caseload size.

In the current study, some interviewees reported that attempts to control caseloads could lead to large waiting lists and long waiting times for service-users, the awareness of which made them anxious. In 2010, Cocks and Cruice found that 73% of the UK-based SLTs that they surveyed were dissatisfied with waiting lists. The current study suggests that waiting lists/times remain a problem for SLTs. A speech and language therapy stocktake by the Centre for Workforce Intelligence (CfWI, 2014) revealed that across the sector (i.e., adult and paediatric services) 40% of need was unmet and that the growth of the workforce would be slower in the coming years due to reduced training commissions. The CfWI advised reviewing the level of unmet need, forecasting declining workforce efficiency and productivity should the picture at that time be perpetuated. Inadequate staffing, mentioned by several participants in the open-ended survey question and by some of the interviewees, could be the underlying reason for both concerns over large caseloads and long waiting times.

Adding to the demands created through workload for the SLTs in this study, were the emotional demands of the job. The SLPSI identified that SLTs found their jobs ‘emotionally stimulating’ but did not provide evidence for whether this was positive or negative stimulation. The qualitative data analysis provided further detail of the emotional demands

that SLTs perceived to be a part of their daily lives: the compassion for, and commitment to service-users felt by the SLTs in this study, could result in some of them worrying about their clients/patients. Furthermore, SLTs interviewed described how they were required to support service-users through stressful health events, such as diagnosis of a life-long disorder or in coping with a degenerative disease. Some service-users felt angry, frustrated and stressed, and SLTs needed to draw on their own emotional resources when caring for their clients. These results align well with a qualitative study exploring the experiences of seven South African SLTs. The authors found that SLTs shared the emotional journeys of service-users, resulting in their daily lives being emotionally draining (Warden, et al, 2008). In addition, past research identified burnout in SLTs who have a high emotional investment in their clients (Bruschini, et al., 2018). Some SLTs interviewed in the current study became distressed when sharing examples of interactions with service-users who were carrying heavy emotional burdens. In addition, several SLTs who were interviewed discussed both the responsibility that they felt for how services are delivered and the responsibility that they felt for service-users. While these feelings of responsibility contributed to participants' sense of 'being' an SLT, they arguably increased the psychological demand that they experienced. Previous qualitative research has identified that having the responsibility of managing patients with serious communication difficulties can be 'onerous' for SLTs (Warden, et al., 2008). The emotional and psychological demands that SLTs face, and the consequences of these, is an under-researched area.

11.2.2.2 Control in the job.

For SLTs interviewed in this study, 'control' related to having autonomy across the scope of their working lives e.g., shaping appropriate trust policy in line with SLT priorities, arranging CPD or supervision, and keeping records efficiently and effectively. It also included making decisions regarding service-user intervention, with regards to intervention 'pathways', length of intervention, type of therapy provided, and dosage. This was a crucial element of 'being' a therapist; and interview accounts demonstrated the importance of this kind of autonomy. Most NHS employees who were interviewed for this study felt restricted both in their ability to affect change and to develop as professionals, by the policies that they were required to operate within. Some lacked control over how services were delivered, and over which clients they supported (e.g., they could be directed to work with clients with whom they had no clinical experience/knowledge). Survey results were

consistent with the qualitative data; administrative policies limiting effectiveness and professional growth, and a lack of control over service delivery models were both identified as sources of stress. There is little previous research reporting the level of autonomy that SLTs tend to have. However, findings in this study are consistent with those of Warden et al. (2008) who reported that South African SLTs struggled to gain a feeling of control in their jobs. Conversely, the current findings contrast with Kaegi et al. (2002) who found that the large majority of the Canadian SLTs in their study had enough authority to do their jobs. These differing results may imply that the settings in which SLTs work impact on the control afforded them.

In this study, the employment sector in which SLTs worked appeared to affect the amount of control they had; those who were self-employed enjoyed considerably more control in their jobs, and this was realised in numerous ways. These included, but were not limited to, being able to select which client group to work with, to determine dosage and the course of intervention, and to monitor and regulate caseload size. Self-employed SLTs were also subject to less bureaucracy than the organizationally employed SLTs. Once more, it is necessary to make comparisons to health professionals other than SLTs, due to the lack of research investigating self-employed SLTs. When compared to employees, the self-employed have been found to have greater levels of autonomy both in the general working population (Lange, 2012; Parslow, et al., 2004; Prottas & Thompson, 2006) and more specifically in AHPs (Brown, Mitchell, Williams, Macdonald-Wicks & Capra, 2011; McClain, McKinney & Ralston, 1992). In addition, qualitative findings have identified autonomy as a reason that dieticians enjoy being self-employed; contributing to increased job satisfaction (Brown, et al., 2011, Schonfeld & Mazzola, 2015). The current finding regarding control for self-employed SLTs therefore adds to the general consensus that those who are self-employed have better control than their organizationally employed colleagues. Because this is the first study to specifically investigate the control that self-employed SLTs have, findings also provide novel information about SLTs who work in this sector.

SLTs surveyed in this study reported that a lack of control was moderately stressful for them. In addition, being unable to meet their professional needs, lacking control over the way services were delivered, and a dearth of CPD activities predicted low job satisfaction for those surveyed. These findings complement past research. While previous studies have not focused on the relationship between control and job satisfaction, higher stress

has been correlated with a lack of control in both American SLTs (Harris, et al., 2009) and Australian SLTs (McLaughlin, et al., 2008). Although Bruschini et al. (2018) did not investigate control specifically for the Italian SLTs in their study, they did report that poor scores on the HSE Management Standards Indicator Tool (which included items that evaluated control) were associated with burnout. The current study identified a further consequence of lacking control, and one not previously reported: qualitative analysis identified conflict within participants when inadequate control over intervention decisions compromised their values/beliefs – specifically the ability to affect change and ensure that a service was client/patient-led.

11.2.2.3 Professional Support.

Of all the psychosocial elements of a job, the survey revealed that lacking support was the strongest predictor of poor job satisfaction, and also contributed significantly to poor general biopsychosocial well-being. The majority of participants in this study were organizationally employed and, generally, did not feel well supported. Most self-employed SLTs were, conversely, in high support jobs. For the SLTs surveyed in this study, a lack of support was characterised by not feeling like a member of the team, lacking sufficient resources, feeling that the public did not value the work that SLTs do, receiving an inadequate salary, and lacking general support. Of these elements of support, pay is an area that previous studies have investigated, identifying that a perceived incommensurate salary contributes to increased stress (Blood, et al., 2002c; Harris, et al., 2009) and lower satisfaction (Blood, et al., 2002b; Cocks & Cruice, 2010: Edgar & Rosa-Lugo, 2007) for SLTs. The survey findings from this study regarding salary are consistent with the extant literature; a perceived inadequate salary predicted lower job satisfaction. Current remuneration for SLTs should be seen within broader events impacting their pay. Agenda for Change, a pay/terms of conditions system, was introduced for NHS staff (with the exception of doctors, dentists, apprentices and some senior managers) in December 2004. For SLTs, it had the effect of reversing the 2000 European High Court Ruling which gave them equality of pay with clinical psychologists (Enderby v Frenchay Health Authority & Secretary of State for Health, 1993; NHS Employers, 2005; Loan-Clarke, et al, 2009). More recently, data available from the “Annual Survey of Hours and Earnings” – which does not include ‘real term’ adjustments (e.g., using the Consumer Price Index to take inflation into account) – showed that the median salary for SLTs decreased from £33,267 in 2012 to

£28,879 in 2018 (Office for National Statistics, 2018). In the current study, 42% of SLTs reported earnings of £20,000-£29,000.

Unhappiness with pay was evident in half of the employed SLTs who were interviewed in this study, adding to the survey results; the perception that salary was inadequate was also correlated with a reported lower wage. However, the more dominant themes identified in the qualitative analysis of this study, across all interviewees, were a lack of validation and concerns over clinical supervision and informal support – the following sections will therefore expand on these two areas.

Interviews conducted during the current study revealed that feeling valued was of notable importance to SLTs, further complementing the quantitative findings of the survey and comments on the open-ended survey question. Survey results revealed that not feeling valued contributed significantly to anxiety. Interviewees reported that they did not feel understood or valued, by other professionals, their senior managers and commissioners, or the general public. Again, these findings concur with existing literature, with SLTs in the USA previously reporting that they did not feel understood or valued (Blood, 2002a, Edgar & Rosa-Lugo, 2007). As part of a UK survey in 2005, 500 SLTs suggested actions that could be taken by the NHS to increase the chances of remaining in or returning to the health service. One of the top four actions suggested was for managers to value/appreciate/recognise the profession more (Loan-Clarke, et al., 2009) suggesting that feeling undervalued has been an issue for UK SLTs employed in the NHS for at least 15 years. More recently, Colesby (2021) found poor representation of AHPs at NHS Trust board level, meaning that few opportunities for increasing understanding of the roles of AHPs or for monitoring staffing were available, leading to little drivers for boards to request commissioning and a cycle of misrepresentation of AHPs. In the current study, qualitative analysis revealed that a lack of understanding by others, coupled with many SLTs feeling undervalued, resulted in frustration and anger for some. There was a sense of inevitability regarding this lack of value and of the profession needing to take responsibility for the status quo. Several SLTs then felt compelled to justify their professional roles, and in effect, themselves as people. Both a lack of understanding and not being valued was deleterious for some. Consequences included negative feelings, a lack of self-worth, loss of hope, defeat, and resignation.

A lack of professional support has previously been identified as contributing to stress and burnout in SLTs (Blood et al., 2002c; Bruschini et al., 2018; Harris, et al., 2009). Conversely, adequate support has been associated with higher job satisfaction (Kaegi et al., 2002; Smith-Randolph & Johnson, 2005). Feeling generally unsupported was identified as negatively impacting on job satisfaction and general biopsychosocial well-being in the current survey and qualitative findings revealed that formal clinical supervision in the NHS was perceived as being inconsistent and sometimes ineffective. Conversely, informal support appeared to be crucial, enabling SLTs to manage the emotional and psychological demands of the job. The finding regarding formal clinical supervision was unexpected, as there is clear and detailed guidance on the RCSLT website regarding supervision, both for employers and employees. Guidance includes explanations of the different types of supervision (managerial, professional and support), recommendations regarding frequency of supervision, the benefits of supervision and the risks of not receiving it (RCSLT, 2017). This finding was therefore further explored.

Firstly, all the interviewees employed in the NHS received less than the minimum amount of professional supervision (1-1.5hrs every 4-6 weeks) recommended by the RCSLT (2017). This lent credence to the perception that supervision was inconsistent. In addition, some participants had different understandings about how often supervision should take place, e.g., one participant suggested every four months. Secondly, interviewees revealed that supervision was not always effective. This could indicate that supervisors do not necessarily possess essential supervision skills, despite the RCSLT (2017) recommendation that supervisors be experienced, competent and appropriately trained. Thirdly, informal support was viewed by all interviewees as being equally important as clinical supervision. This contrasts the RCSLT website information, which states that support 'tends to be more superficial' than supervision. Qualitative analysis revealed that informal support tended to be pastoral in nature and had a cathartic effect for SLTs. It helped them to process their emotional responses to their work experiences and needed to be frequent and time sensitive to be effective, as waiting for months in order to 'offload' following upsetting events was futile. This informal support was often lacking for employed SLTs, but more available to self-employed SLTs. There is some overlap in the RCSLT (2017) guidance regarding the purpose of supervision and informal support. It states that one aim of *supervision* is restorative i.e., developing a sense of professional self-worth and dealing with job-related stress. Alternatively, the purpose of informal support, which is ongoing and ad-hoc, is stated as being 'to assist a practitioner in learning about everyday

workplace practice and procedures.' However, the guidance also states that informal support allows access to pastoral support and can lead to reduced stress levels and enhanced ability to manage distressing or complex situations. Participants in this study appeared to recognise this overlap, discussing the need to raise stress in supervision sessions, but also to use informal support to deal with ongoing stressful situations. Finally, and most importantly, the RCSLT website states that supervision 'should be valued' within the culture of every organization, and should 'sit alongside good practices in recruitment, induction and training'. This study revealed that supervision was not prioritised for any of the employed SLTs; there was often little time for supervision, and it tended to be cancelled in favour of clinical priorities. This might reasonably result in SLTs and their employers not accessing and acting upon the RCSLT information on supervision effectively.

In contrast to the above findings, most of the self-employed SLTs interviewed enjoyed a level of autonomy which enabled them to arrange supervision with which they were satisfied. They attended regular supervision, selected supervisors who were skilled and ensured that they received informal support when needed.

11.2.3 JDCS job types typically held by SLTs.

The way in which the psychosocial elements of demand, control and support within the work environment individually affect the well-being of SLTs was analysed in the previous section. The JDCS model (Johnson et al., 1988; Karasek, 1979) enables exploration of the combined effect of these factors. The model was applied to the data collected from the survey. Of this sample, 17% were in IsoStrain jobs, jobs that are characterised by high demand, low control and low support; and that pose the biggest risk for becoming psychologically vulnerable to anxiety, depression, somatic symptoms and social dysfunction. The type of JDCS job that an SLT held was also associated with the employment sector in which they worked. A similar proportion of each group held Active jobs, characterised by high demand and high control (42% of organizationally employed SLTs, and 40% of self-employed SLTs). However, over one third (35%) of organizationally employed SLTs had High Strain jobs and almost two in five (37%) in the NHS had High Strain jobs. In contrast, only three self-employed SLTs had High Strain jobs, whereas over half (54%) had Low Strain jobs. These jobs are characterised by low demand and high control. Although the proportion of self-employed SLTs in the sample did reflect the

demographics of SLT workforce in the UK at the time, the group was relatively small (n=58).

The effect that job types have on well-being will be discussed in the next sections.

11.2.4 The Job Demand Control Support (JDCS) model.

The findings of this study lend theoretical support for the additive effects of the JDCS model on both occupational (job satisfaction) and general biopsychosocial well-being, when applied to the SLT workforce. Support for the additive effects of the model corroborates the findings of previous research with other occupational groups (Häusser et al., 2010; Van der Doef & Maes, 1999). Häusser et al. (2010) stated that an additive effect is almost always found if the sample size is large enough, and the sample size of 632 in the current study may have yielded sufficient data for additive effects to be identified.

Theoretical support was not found for the interactive effects of job demand, control and support (i.e., the buffering effect of support on the relationship between demand and control) on job satisfaction, or on general biopsychosocial well-being. According to both Häusser et al (2010) and Van der Doef and Maes (1999), support for the interactive effects in the studies they reviewed was weak overall. Both identified that support for the interactive effects of JDCS was dependent on whether aspects of job control corresponded to the specific demands of a given job. This might go some way to explaining why these interactive effects were not supported in this study. Although the SLSPI contains items that are specific to SLT job demands e.g., workload, including caseload; and also specific to the control that SLTs have, e.g., control over how services are determined, items examining demands are not explicitly matched to items investigating control.

This study therefore found partial support for the JDCS hypotheses.

11.2.5 The occupational well-being of SLTs practising clinically in the UK.

Domain specific subjective well-being (SWB) was operationalised in this study as job satisfaction. Furthermore, it was recognised that satisfaction is not the only indicator of a person's views about their job. Therefore, information was gathered about whether participants felt their jobs were worthwhile and whether they felt happy in their jobs (i.e., the affective element of SWB). In addition, stress was investigated. Finally, qualitative data

supplemented the survey information, as participants discussed the love and feelings of pride that their jobs brought them, but also the stress and resulting anxiety that the job could cause.

11.2.5.1 Job satisfaction, positive feelings about the job and stress.

Research in the USA has shown SLTs to have high job satisfaction (Hutchins, et al., 2010; Kalkhoff & Collins, 2012). The current UK-based study found that 40% of the survey participants had high job satisfaction, providing some corroboration of existing information, but suggesting that high job satisfaction was not always the case. Just under a quarter of participants surveyed reported low or very low job satisfaction, with the variables of the JDCS model explaining over half (51%) of the variance in job satisfaction. The highest job satisfaction was associated with Low Strain Collective jobs, and with being self-employed. However, SLTs surveyed in this study were mostly happy in their jobs and felt that their jobs were worthwhile, and some responses to the open-ended question included statements about loving the job. Qualitative analysis of interview data revealed that SLTs were passionate about what they do and had a sense of pride in their work.

In addition to experiencing satisfaction in their jobs, SLTs in this study reported that stress was ever-present. Qualitative analysis revealed chronic stress as a consequence of the daily demands of the job for all the employed SLTs, with periods of acute stress linked to specific experiences for some. The majority of SLTs surveyed in this study (61%) experienced mild to moderate stress in their jobs, with a sizeable proportion (31%) experiencing moderate to severe stress, and stress was mentioned twice as often as loving the job on the open-ended survey question. The average stress experienced was similar to that of early reports from the USA, where Fimian et al. (1991) reported moderate levels of stress in school based SLTs. However, the findings from this study differ from later studies in the USA, which found comparatively low levels of stress, both amongst those SLTs who worked in schools (Blood et al., 2002c; Harris et al., 2009) and healthcare (Blood et al., 2002a). It is possible that differences between previous studies and this one are due to the setting/sector in which the research has taken place. Indeed, while the self-employed interviewees in this study did experience stress, their responses to work tended to be described more in terms of frustration, and the survey revealed that they experienced statistically significantly less stress than their employed colleagues.

11.2.5.2 The role of individual differences.

It has been recognised that the relationship between the psychosocial work environment and occupational well-being is not straight-forward (Cooper, Dewe, & O'Driscoll, 2001) and that individual differences may mediate a person's cognitive appraisal of their job. This is the first study to have considered the role of individual differences in the relationship between an SLT's work and their job satisfaction. SLTs in this study tended to have high generalised self-efficacy and self-esteem; they were also optimistic, had an internal locus of control and low negative affect.

Both the longitudinal element of Phase One and the qualitative findings provided further detail on some of these findings. Several of those who were less satisfied than their colleagues at the time of the first survey had changed their jobs by the time of the second survey, possibly demonstrating an internal locus of control, as they actively played a role in their own futures. The self-employed SLTs who were interviewed had also played a part in controlling their own destinies regarding work, by choosing to move employment sectors. This is a relatively bold move, because while the independent SLT sector is growing in the UK, speech and language therapy has been an element of public health care since the early twentieth century (Robertson, Kersner & Davis, 1995); and provided through the NHS since its inception; with the NHS still the dominant employer of SLTs in the UK.

It was further found that the type of job that an SLT held predicted their individual differences. Those who held Isostrain jobs tended to have lower self-esteem, self-efficacy, and optimism than those in other job types. In addition, they were more likely to have higher negative affect and an external locus of control. These findings are in line with previous research, which has found that individual differences are malleable, and can fluctuate in response to the psychosocial job environment (e.g., Cox & Jackson, 2005; Maslach & Leiter, 2008; Xanthopoulou, et al, 2007).

In turn, individual differences have been found to predict well-being outcomes in nurses (Edwards & Burnard, 2003). Specifically, for SLTs in this study, negative affect, locus of control and optimism all mediated the relationship between work and occupational well-being. There is only one previous study that investigated the role of individual differences when considering the SLT workforce. SLTs with higher negative affect were found to be

more likely to leave the profession by Mclaughlin et al. (2010). That study did not focus on well-being as an outcome.

While the relationship between a job type and occupational well-being outcomes was partly explained by the inclusion of dispositional traits as mediators, total mediation did not occur, suggesting that the psychosocial environment increases the risk of psychological harm over and above the influence of individual factors

11.2.6 The general biopsychosocial well-being of SLTs practising clinically in the UK.

This is the first known study to investigate the global subjective well-being of SLTs, beyond domain specific well-being. Although the General Health Questionnaire-28 is a metric that has not been used with SLTs before, it has been employed in numerous studies investigating general biopsychosocial health in other occupational and general populations. A selection of previous research is shown in Table 11.1, for comparison purposes. Not all studies reported the percentage of the sample that achieved 'caseness'. Where central tendency was reported, this could not always be compared with the current study, because the alternative GHQ-12 was used in some cases, whereas this study used the GHQ-28.

Approximately one in two (53%) SLTs in the current sample achieved 'caseness' on the GHQ-28. In addition, almost 40% were classified as having severe distress i.e., symptoms that were unlikely to resolve without intervention. The SLTs surveyed reported that they were not feeling well and in good health, but instead felt rundown. They also felt that they spent longer than usual over routine tasks. Furthermore, they reported that, on the whole, they were not doing things well, and were feeling dissatisfied with the way that they had carried out tasks. Scores were stable over a three-month period of time, indicating that responses were unlikely to be the result of transient mood. Qualitative analysis of both the open-ended survey question and the interviews provided further evidence for the biopsychosocial consequences of stress at work. Survey respondents reported feeling overwhelmed, anxious, disheartened, demotivated, and demoralised. More than half the interviewees who were organizationally employed reported feeling anxious or worried; and unhappiness, feeling lonely, changes in mood, and lacking concentration were also discussed. Participants also reported rumination, and sleep difficulties. Several physical effects were mentioned, including feelings of nausea and headache.

Table 11.1. A selection of previous GHQ results

Authors (country)	Date	Population studied (number in sample)	Version of GHQ used	Results (% achieving caseness or M scores)[a]
Ewen: this study (UK)	2020	SLTs (n=632)	GHQ-28	53% Employed: 55% Self-employed: 34% Mixed:50% M=24, SD=12.1
Walker, et al. (UK)	2015	Therapeutic prison officers (n=57)	GHQ-28	95%
Crawford, et al. (UK)	2009	Remote & mobile workers (interview n=31, survey n=243)	GHQ-28	64%
Khamisa, Peltzer, Ilic & Oldenburg (South Africa)	2017	Nurses (n=895)	GHQ-28	60%
Wall, et al. (UK)	1997	NHS workers (n=11,637)	GHQ-12	27%
Hinz, et al. (Germany)	2016	Teachers (n=1074)	GHQ-12	26.2% (comparison group: 'normal population' – 13.1%)
Arafa, Nazel, Ibrahim & Attia (Egypt)	2003	Nurses (n=412)	GHQ-30	22%
Rodwell & Gulyas (Autstralia)	2015	Allied health professionals (n=113)	GHQ-12	M=24.61 (SD=3.65)
Moreno-Abril, et al., (Spain)	2007	Teachers (n=498)	GHQ-28	Mean scores ranged from 1.0 (SD=1.4), for teachers without teaching qualifications to 12.9 (SD=8.3) for teachers who had been physically assaulted

Note. GHQ-Likert thresholds for achieving caseness: GHQ-28: 23/24, GHQ-12: 11/12

[a]The results of this study are reported first, the remaining studies are ranked according to percentage 'caseness' in the sample

The current cohort's scores were worse than those that have previously been achieved by NHS workers (Wall, et al., 1997), teachers (Hinz, et al., 2016; Morena-Abril, et al., 2007) and nurses in Egypt (Arafa, et al., 2003), but better than those achieved by South African nurses (Khamisa et al., 2017). Finally, they were better than therapeutic prison officers (Walker, et al, 2015) and remote and mobile workers (Crawford et al., 2009). Using the Likert mean score instead of the binary method recommended by Goldberg (1972), SLTs in the current study achieved 'caseness', a result that is aligned with that of AHPs in Australia (Rodwell and Gulyas (2015). Further comparison of these two samples is problematic, as different versions of the metric were used in each study.

Once more, results appear to be somewhat dependent not only on profession, but also on specific setting or conditions in the job e.g., Morena-Abril (2007) grouped teachers in their study according to several variables and found dissimilar results on the GHQ-28 for different groups e.g., having a high number of pupils in a class (M=4.3, SD=5.9), or whether the teacher had been physically assaulted by a pupil (M=12.9, SD=8.3). In the current study, the influence of the psychosocial work environment was again apparent. Over one fifth (23%) of the variance in general biopsychosocial well-being was explained by the variables of the JDCS model, with those in IsoStrain jobs, who were typically organizationally employed, tending to have the worst biopsychosocial well-being scores. Finally, employment sector again contributed to results. The self-employed SLTs had significantly lower GHQ-28 scores than those who were organizationally employed, indicating that they enjoyed better general biopsychosocial health than their employed colleagues.

11.2.7 Taking responsibility for well-being: strategies & resilience.

11.2.7.1 Strategies.

Concerning domain specific well-being, SLTs in this study were not passive regarding their well-being. Interviews revealed that they had a sense of agency regarding their well-being and employed behavioural and psychological adaptations, as well as self-care strategies outside of work, in their attempts to safeguard their welfare. However, the longitudinal findings of the survey revealed that making positive personal changes (e.g., doing more regular exercise, starting a hobby, going home on time) did not improve job satisfaction or general well-being. Conversely, changing jobs resulted in an improvement in job

satisfaction. Examining whether this improvement is maintained or whether it was a temporary spike in satisfaction was not within the scope of this study.

Focusing specifically on moving from organized employment to self-employment, Georgellis and Yusuf (2016) followed individuals drawn from the British Household Panel Survey over a period of six years (for up to four years before becoming self-employed and up to five years after). Depending on follow-up, approximately 520 people were surveyed; findings were that job satisfaction gains for those transitioning to self-employment were not necessarily permanent. However, all the interviewees in the current study who were self-employed reported having had more than five years' experience as independent SLTs, with the two longest being 12 and 14 years. All were also happy and satisfied in their jobs, and apart from one, they reported an improvement in their well-being since becoming self-employed. Given the length of time that they had been self-employed, this improvement appeared to have been sustained. Therefore, it is tentatively suggested that SLTs who move from organized employment to become self-employed often are likely to maintain their improved levels of well-being.

11.2.7.2 Resilience.

Resilience of the NHS workforce has been in focus for some time and continues to be so. Over a decade ago, a review exploring resilience among nurses reported that improved resilience was found to reduce vulnerability to workplace adversity (Jackson, Firtko & Edenbourough, 2007). It has also previously been reported that workplace changes due to 'neoliberal' work policies, austerity, and NHS restructuring has meant that there is little time for elements that support GP resilience, such as better contact with colleagues and a good work-life balance (Cheshire, et al., 2017). Cheshire and colleagues concluded that an individual could only 'do so much' to manage their stress, and that resilience building should move beyond the individual to include systemic work issues. More recently, several recommendations to support both organisational resilience (e.g., appropriate staffing and true collaboration with no fragmentation of services) as well as develop personal resilience (e.g., developing mentoring relationships and practising healthy coping strategies) in nurses have been proposed (Duncan, 2020).

Resilience has not featured in previous research with SLTs. This study presents some initial findings that might serve as a reference point for further investigation. SLTs interviewed for this study knew that resilience was necessary for the work that they do, but

there was a feeling that resilience was poorly understood. Furthermore, in addition to acknowledging the role of individual resilience, they also viewed resilience from an ecological perspective – organizational resilience and the support of colleagues was deemed important. For participants, personal resilience was viewed as being complex – it was not necessarily constant and at times failed to protect against stress. Interviewees felt that they *were* resilient, but that because normal practice required them to be resilient as part of their everyday experiences, 'tipping points' – in response to particular traumatic experiences – occurred because their personal resources were already depleted. This complements the notion that the amount individuals can do to manage stress is limited and that addressing systemic issues is also necessary (Cheshire, et al., 2017).

11.2.8 Conclusions.

Before the well-being of SLTs practising clinically in the UK can be discussed, an appreciation of what 'being a speech and language therapist' meant to the participants in this study is necessary. Their views of themselves as SLTs, and on whether they were able to meet the core elements that defined these views, affected their psychological responses to their jobs.

For the participants in this study, 'being' an SLT meant 'providing intervention' or 'doing therapy'. Participants described well-defined and specific elements to this provision of therapy that appeared to be based on values and beliefs they held: that being of service to others was important; that therapy should be client-centred; that people had the right to access communication support regardless of financial status; and that responsibility for the way in which a service was delivered, and to service-users themselves lay with the therapist. When these tenets were compromised, there was a negative effect on the mental health of the SLTs.

The daily working lives of the participants presented challenges that threatened their ability to realise their values. Many experienced moderate to severe levels of occupational stress, with the principal stressor for SLTs being demand as a result of heavy workloads and a lack of time to complete tasks. Unachievable or irrelevant targets, large caseloads, large waiting lists and long waiting times left SLTs feeling overwhelmed, exhausted, incompetent and inadequate. This compromised their ability to affect change and to provide client-centred care. There was a sense that participants spent more time, personal resources

and energy to meet demands than they could maintain. This unsustainability has implications both for the long-term capacity of SLTs to continue to work in a way that ensures quality provision for service-users; and for SLT well-being.

The responsibility that the SLTs in this study felt for the way in which a service was delivered was hampered by the lack of control that they experienced in their jobs, which significantly predicted low job satisfaction. Participants who were employed felt unable to ‘meet their professional needs’, which translated to a mismatch between their values and their behaviours. Their clinical actions were determined by service constraints that, once more, resulted in an inability to affect change and build therapeutic relationships. This led to psychological conflict, with participants describing cognitive dissonance and changes to their sense of self. They demonstrated agency by attempting to gain some control, mainly through unsanctioned measures, however this could lead to feelings of guilt and increased stress, and some SLTs left their jobs and sometimes the profession.

SLTs in this study felt a lack of validation and support at work, which contributed both to low levels of job satisfaction and poor general biopsychosocial well-being. Feeling that the public doesn’t value the work that SLTs do specifically predicted their low general biopsychosocial well-being, which was particularly characterised by high levels of anxiety. A pervasive lack of understanding of the profession; by commissioners, managers, other non-SLT professionals, and the public resulted in SLTs feeling frustrated and angry, and led to them feeling compelled to justify their professional roles and ultimately themselves as people. This need to justify self was, perhaps, a reflection of how the professional identity of the SLTs included some of their core personal values. A loss of hope; a lack of self-worth; and feelings of resignation and defeat were some of the psychological consequences of feeling undervalued.

The participants in this study, however, attempted to take responsibility for their well-being. They employed both behavioural and psychological adaptations at work as well as self-care strategies outside of work. They also recognised the need for resilience at work and felt that they were resilient. However, their well-being strategies were sometimes futile, as evidenced by a lack of change in their job satisfaction over three months when they had made positive personal changes. Their resilience could also fail to protect them, with over half of the workforce being vulnerable to psychological difficulties. High strain jobs were held by a third of participants in this study and were responsible for low job satisfaction

and poor general biopsychosocial well-being of participants. While individual differences mediated this relationship to some extent, this study provided support for the additive theory of the JDCS model.

Findings from this study align with the views of Cheshire et al. (2017); that the amount an individual can do to manage stress is limited and that addressing systemic issues is necessary. The next section will describe recommendations for doing so.

11.3 Recommendations for Practice, Training and Staffing

The BPS Code of Human Research Ethics states that the aim of 'generating psychological knowledge should be to support beneficial outcomes' (British Psychological Society, 2014, p11). The findings from this research could be used to inform future directions with regards to the health and well-being of the SLT workforce. Responses from a large sample of SLTs, and the detailed contributions of a sub-sample of participants involved in this study have led to the following suggestions, for implementation both by employers and by wider policy shapers.

11.3.1 Holistic appraisal of SLT job design, undertaking change.

The first step in supporting SLT well-being is to ensure that there is a clear understanding of the psychosocial composition of their jobs. The focus of this study has been broad, without the scope to assess individual workplaces. Leka, Van Wassenhove and Jain (2015) argue that psychosocial risks are embedded within work organization, although a false distinction between the two is sometimes made. This study has revealed a combination of potential workplace stressors that predict SLT job satisfaction, suggesting employers consider the overall psychosocial design of SLT jobs, instead of viewing occupational factors individually. The JDCS model has proved a useful framework for describing SLT jobs, and it could be used in the future to gain detailed knowledge about different elements that constitute particular SLT jobs. A useful resource for employers is the HSE Management Standards Indicator Tool, a step-by-step risk assessment approach. Risk is likely to be different in different settings; and depending on employer. It is therefore essential that the voices of SLTs who are primarily clinical are heard and used to inform this appraisal; collaboration between managers and clinicians is a necessary element of the process. Working parties could facilitate this appraisal, which should include details of

the demands (physical, emotional, psychological and in terms of workload), control (e.g., levels of autonomy regarding service delivery) and support (supervision and informal support) that characterise a job. This work will potentially be difficult, given the prevailing culture in the NHS, which places responsibility for well-being on the individual by encouraging self-reliance and coping (Harvey, et al, 2009). However, clear knowledge of the psychosocial elements of SLT jobs is the starting point for change, and once this knowledge is in place, areas that require development can be addressed. This research has identified that addressing caseload sizes, staffing levels, supervision and support should be priorities.

11.3.2 Caseload sizes and staffing levels.

Workload, usually as a function of unmanageable caseload sizes, was the biggest cause of stress for SLTs in this study. Unmanageable workloads are inextricably linked to inadequate staffing levels. In America, ASHA publishes policies and recommendations around caseload and workload to support SLTs. In the UK, the British Psychological Society publishes briefing papers for NHS commissioners, which recommend staffing levels to 'enable the provision of effective and efficient psychological care' in different clinical settings (McKenzie-McHarg et al., 2016, p5). A review of caseload sizes and staffing levels must be a priority, and should be led by the RCSLT, with the aim to have policies and recommendations for practising SLTs.

11.3.3 Improving the way speech and language therapy is understood and valued.

Feeling undervalued was a strong theme from this research. As the professional body of SLTs, the RCSLT is well placed to influence the way that other professionals, commissioners and the general public understand and value speech and language therapy. It is recommended that consultation between SLT managers and RCSLT policy leads prioritise this and generate strategy that aims to improve the situation. If the profession is better understood and valued, this might have implications for the funding of services specifically, and for the well-being of SLTs more generally.

11.3.4 Improving support and supervision.

This study found that support was the most important predictor of both job satisfaction and general well-being, and that support was not prioritised for many SLTs. To begin improving the supervision and support for SLTs; recognising that supervision must be prioritised and frequent, and that supervisors should be skilled, is necessary. Existing RCSLT advice should be used as a starting point for developing adequate support.

11.3.4.1 An update of, and adherence to, RCSLT advice about supervision and support.

It is recommended that the RCSLT advice on supervision and support is updated. Once more, working parties from a wide selection of clinical settings would prove useful in ensuring that clinicians' needs are represented. This research suggests that a starting point should be revisiting how the current minimum amount of supervision recommended can be encouraged in practice. Employers should prioritise supervision, and allocate time for it, in line with existing RCSLT advice. In addition, the RCSLT needs to reframe emotional and psychological support so that its importance is recognised, and so that it is included within formal supervision.

11.3.4.2 Sharing good practice.

There was variation in the well-being of the participants in this research, and in how their jobs were designed. Therefore, good practice should be identified and shared across NHS trusts and localities. For this particular workforce, the psychosocial work environment appears to be associated with the employment sector in which an SLT works. Because the SLTs in this research who were self-employed appeared to be better supported than those who were employed, good practice should be shared across sectors. Since the RCSLT website includes information on the role of supervision and the frequency at which it should take place, and because they represent all SLTs regardless of whether they are employed or self-employed, they are in a position to be able to facilitate this cross-sector learning.

11.3.4.3 New ways of providing supervision and support.

This thesis was written during the UK 'lockdown' that was implemented in response to COVID-19, which has meant that new ways of practicing have emerged during this time. The researcher has had personal experience of providing online supervision to a colleague who was previously supported in the setting in which she works. This has resulted in a substantial decrease in the time needed in which to provide the service. One of the findings

of the current research was that supervision was sometimes not provided due to the time it took – particularly when an SLT was required to travel to another venue for their supervision. The provision of distance, online supervision might be a practical way of addressing this difficulty.

11.3.4.4 Training supervisors.

This research has revealed that the psychological and emotional elements of supervision need to be better recognized; but that staff are sometimes ill-equipped to provide the supervision needed to provide this support. There is a restorative and rehabilitative purpose to supervision, both of which are vital in reducing emotional exhaustion (Bernard & Goodyear, 2013). The Systems Approach to Supervision (SAS, Holloway, 1995) includes counselling skills, emotional awareness and self-evaluation as skills necessary for effective supervision. However, Fleming and Steen (2003) maintain that it is not enough to assume that a qualified clinical psychologist has the necessary skills to be a good supervisor, and that training is needed. This study suggests that this might be the case for SLTs too, warranting the need for better training. Ideally, training around supervision should start at an undergraduate level; and continue to be delivered as part of CPD post qualification.

11.3.5 The development of SLTs' personal resources.

SLTs in this study were found to demonstrate agency regarding their well-being, taking responsibility for their feelings and reflecting on their ability to be resilient. Resilience is a complex construct, and it is not within the scope of this thesis to fully explore it. However, this research identified that SLTs generally have high self-esteem and self-efficacy, which are attributes that characterise resilience (Earvolino-Ramirez, 2007; Garcia-Dia, DiNapoli, Carcia-Ona, Jakubowski & O'Flaherty, 2013). In addition, recommendations to support the development of personal resilience (e.g., developing mentoring relationships and practising healthy coping strategies) in nurses have recently been proposed (Duncan, 2020). Resilience is therefore something that should be further explored, perhaps initially through the self-reflection that occurs during supervision, but also through training that is focused on developing personal resources, such as self-esteem and self-efficacy, both at pre-registration and during continuing professional development.

While individuals do bear some responsibility for their own well-being, there is acknowledgement that systemic work and organizational issues should be addressed (Cheshire et al., 2017; Duncan, 2020). The RCSLT, employers and universities providing SLT training all have an obligation to ensure the well-being of the workforce. Responsibilities differ, although there is some overlap. Furthermore, collaboration between all three is important. Figure 11.1 provides a visual depiction of the recommendations for practice, training and staffing.

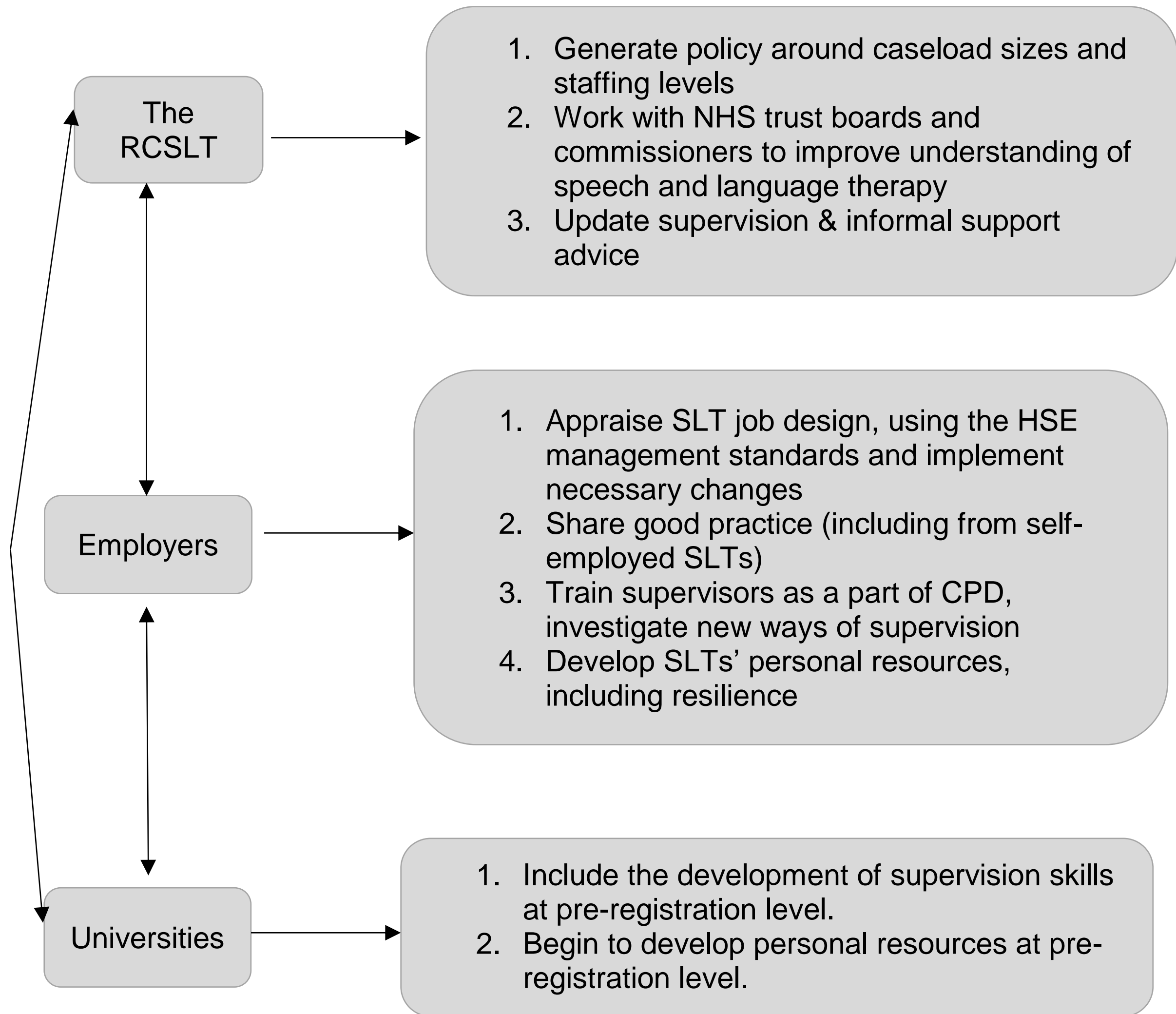

Figure 11.1 Recommendations for practice, training and staffing

11.4 Suggestions for Further Research

The literature review conducted as part of this study identified that previous research into SLT well-being is sparse, particularly in the UK. Potential future directions were suggested at the conclusion of the literature review and this research has begun to address some of these. The study was longitudinal, included the role of individual differences of participants in predicting well-being and utilized a theoretical model to frame the research. This research in turn suggests further avenues for exploration.

More mixed-methods research into SLT well-being could contribute to the literature base by focussing on different sub-groups of SLTs in the UK e.g., according to employment sector or work setting. Qualitative research could be conducted first in order to generate

theory, as the sparsity of previous recent, context-specific research makes it is difficult to use this as a reference point. In addition, research could use triangulation methods e.g., analysis of work diaries/calendars, alongside self-report; to overcome potential bias due to self-report. Finally, future studies should employ longitudinal designs which could investigate the possible causal links between work stressors and well-being.

Colleagues should consider the usefulness of the JDCS model and implement it in future studies that investigate SLT well-being in specific contexts. Given that an instrument to measure SLT occupational well-being might be useful for practitioners if they are to gather information on the well-being of their workforces, development of a contemporary scale with items that are unequivocal, and where interpretation is unambiguous, would be useful. Furthermore, careful matching of items that assess demand, to items that investigate control, might allow more effective assessment of the interactive element of the JDCS model.

Future research could investigate to what extent SLTs are resilient, or how this resilience might be employed to protect against stress. Ecological or organisational resilience in SLT teams could also be explored. Research could also investigate whether training to harness, support and develop personal resources such as optimism; is effective in enabling SLTs to respond more effectively to intractable challenges at their workplaces; and in improving occupational well-being. If so, this training could be included in pre-registration courses.

Research into the understanding that commissioners have about the work that SLTs do, the way that they fund services, and importantly, how to improve their understanding; might be beneficial in improving funding and therefore possibly having a positive effect on staffing levels. Research with SLT managers to identify how they can influence commissioners might also prove useful.

Collaboration with clinicians is important to consider when planning future research. More work needs to be done in determining how caseload size might contribute to the occupational biopsychosocial well-being of SLTs in the UK. Determining an optimal caseload size that is manageable for SLTs needs to be done on a setting-by-setting basis, with input from front-line SLTs who have first-hand experience of how the complexity of service-user needs in their unique settings impacts on non-direct client time and takes into

account individual elements that contribute to time spent per patient e.g., travel time between service-users.

Finally, when conducting research into SLT well-being, collaboration with the RCSLT is strongly recommended. The RCSLT surveyed its membership in May 2020, to gather information about the well-being of the workforce during the COVID-19 pandemic. The results of that survey should be compared to the findings of this research, which took place before the pandemic, and this might prove a useful starting point for further collaboration over research into SLT well-being.

11.5 Strengths and Limitations of the Study

This research was the first of its kind to directly investigate the occupational as well as general biopsychosocial well-being of SLTs practising clinically in the UK; to use a theoretical model to frame the research and to focus on well-being as an outcome per se. As such, it contributed original knowledge to the field. The two most recent UK studies to include well-being were conducted a decade ago, however, one focused specifically on experiences of migrant SLTs (Cocks & Cruice, 2010) and the other on recruitment and retention of SLTs (Loan-Clarke, et al., 2009). While job satisfaction was identified as a reason to stay in the NHS, and stress as a reason to leave by Loan-Clarke, et al. (2009), the reasons behind job satisfaction or stress were not fully identified. It is arguably important to identify, assess and manage the underlying reasons for these feelings about the job, to support recruitment and retention. This research identified these underlying reasons, addressing a gap in the literature.

The mixed methods explanatory design of the study was another strength of the research. The attempt to answer the research questions and gain a comprehensive understanding of the well-being of SLTs in the UK capitalised on the positive aspects of both quantitative and qualitative methods. Quantitative results from Phase One yielded large-scale data which were then corroborated both by the qualitative element of Phase One and by the interviews from Phase Two, which allowed for convergence of information from different sources.

Integration may take the form of transformation and/or conversion of data (e.g., from qualitative to quantitative or vice versa), contrasting and comparing data from different

sources and using findings from one study to inform the design of the next (Bazeley, 2018). In addition, integration occurs when each phase of the project yields both quantitative and qualitative data, as opposed to one phase being the 'quantitative phase' and the next being the 'qualitative phase'. Onwuegbuzie (2018) and Johnson (2018) both recommend that a phase is viewed as 'nomothetic' or 'idiographic', in place of 'quantitative' or 'qualitative'. This project utilised numerous forms of integration. Both quantitative and qualitative data was gathered at both phases. Quantitative findings from Phase One were used to plan the qualitative design for Phase Two. Themes detected in the qualitative data in Phase One were compared to those that were identified during the semi-structured interviews in Phase Two and this information was then viewed in relation to the quantitative data from Phase One.

11.5.1 Phase one and phase two.

11.5.1.1 Phase one.

A strength of the quantitative phase of the study was the sample size, of 632 participants. To the researcher's knowledge, this is the largest study of SLTs in the UK to date. The sample size met the requirement, as determined by a power analysis, necessary to detect any relationship between variables being investigated. In addition, the sample came from across the whole of the UK and the four home nations were represented. The numbers of men and women in the sample were also representative of the workforce more generally. Moreover, the sample included both paediatric SLTs and those working with adults, as well as employed and self-employed SLTs. This is the first time that any research has specifically included the self-employed sector of the UK SLT workforce. In addition, the longitudinal element of Phase One allowed investigation into changes in well-being and the possible reasons for these changes, although not all variables were measured at the second time point. These elements of the study could support the generalization of findings for the whole workforce, as well as for specific sub-groups, and could be of use to policy makers.

Bias can never be eliminated, nevertheless, it should still be recognised and managed as far as possible (Pollock, 2020; Šimundič, 2013). This study was at risk of several sources of bias. Self-report was used, which could have resulted in participant response bias as well as common-method variance (including acquiescence bias, transient mood state, item

ambiguity and social desirability). While unequivocally identifying whether the survey results were affected by response bias is not straightforward (Villar, 2011), the questionnaire was carefully designed and piloted in an attempt to minimise this. In addition, a strength of this phase was its longitudinal element, as repeated measurement can go some way to ameliorating the effects of common method variance, including mood and context (Siegrist, et al., 2004).

The survey instrument used in Phase One was published online. While self-administered survey modes may reduce the impact of social desirability (Villar, 2011) the online survey could have resulted in selection bias, resulting in an unrepresentative sample (Batterham, 2014). However, an attempt to ameliorate this bias was made through offering a paper-based alternative (advertised in the RCSLT *Bulletin*, June 2018) to the online survey, although no potential participants made use of this offer. Volunteer bias was therefore a possibility, with non-responses meaning participants who did respond to the survey may not have been representative of those invited to take part, and extrapolation of results to the population under review may not be possible (Jackson & Smith, 2003). However, Knudsen, Hotopf, Skogen, Øverland & Mykletun (2010) caution against repeatedly approaching non-participants – an important ethical principle is that participation in research projects is voluntary, and repeated approaches will, at some point, therefore become an ethical issue. In addition, Knudsen and colleagues found that continued attempts to recruit non-responders was unsuccessful, and that non-response bias was a greater threat to prevalence studies than to studies of associations between exposures and outcomes. Much of this study investigated the relationship between stressors and well-being, therefore falling into the latter category.

Internal validity is always more important than generalizability; it is never appropriate to generalise an invalid finding (Mant, Dawes, & Graham-Jones, 1996). Considering the internal validity of this study, all published scales and all single items used had previously demonstrated construct validity, and the published scales were tested during this study and found to be reliable. Previous studies (e.g., de Lange, Taris, Kompier, Houtmans & Bongers, 2004) have confirmed a causal relationship between job demands, control and support, and well-being, lending support to the validity of the current findings. While every study has confounding variables that may cause bias (Pollock, 2020), the effect of individual differences on the relationship between work and well-being was considered, going some way to accounting for these. Triangulation further facilitated validation of data

through cross verification from three sources: the quantitative survey data, the qualitative data from the open-ended survey question and the interview data.

While the SLPSI was a useful, validated instrument for operationalising demands in a way that was specific to SLTs, and the only one of its kind to be identified, it was found to have some shortcomings. Firstly, several items might have been open to interpretation by respondents e.g. 'I lack support'. Secondly, the SLPSI contains four subscales which are 'sources of stress' and two which are 'manifestations of stress'. This means that, if using the instrument in a research study, it could be used to test both predictor variables (stressors) and outcome variables (emotional/fatigue and biobehavioural consequences). However, the SLPSI yields an 'overall stress score', which is based on a mean score of all the subscales, including the four 'sources of stress' subscales and the two 'manifestations of stress' subscales – it is therefore unclear as to what this score measures. Previous studies using the SLPSI are evidence of this lack of clarity e.g., Poché, Tassin, Oliver, and Fellows (2004) mentioned that the 'biobehavioural manifestations' subscale (which measures outcomes of stress) was seldom a cause for stress in their thirty participants. Blood et al. (2002c) reported the total mean score for their participants and stated that this meant that 'stressors were barely noticeable' (p136) despite the total score including stress manifestations e.g., feeling anxious. It is questionable as to whether the 'sources of stress' subscales can simultaneously be used to measure the predictor variables (i.e., stressors) and then used again when calculating the 'total stress score' which claims to be an outcome (i.e., resulting stress). However, the SLPSI (as well as the GJSS and GHQ-28) did achieve good internal consistency, demonstrating reliability of the scales.

11.5.1.2 Phase two.

A strength of the qualitative phase of the study was the use of interpretative phenomenological analysis to examine the data. This method enabled the voices of individual SLTs to be heard and provided them with the opportunity to share their own interpretations of their experiences. It then enabled the researcher to further interpret the information provided by participants (the double hermeneutic) and acknowledged that 'bracketing' could only partly be achieved. Finally, it facilitated the identification of what was important to participants in the creation of themes. This analysis added depth and nuance to the quantitative element of the research. Participants were recruited from those who had taken part in the survey, which enabled findings from the first phase of the research to be further investigated in the second as required. A further strength of the

interviews was that the investigator was an insider researcher. This meant that she understood the profession, and some of the jargon used within the profession. There was a sense that the interviewees felt safe enough to explore their feelings. Although several were openly emotional and a few were tearful when recounting their experiences, none asked to pause or to terminate the interview. Instead, comments such as 'you know what it's like' were made. The interviewer and interviewee appeared to be 'in it together' and it appears that this encouraged openness. The investigator's experience working as an SLT and needing to facilitate interactions where personal information is shared by service-users during initial consultations, in a relatively short time period, meant that she was able to use these skills during interviews. She was also practiced at being open and non-judgemental, and in attempting not to apply presuppositions to interactions, which helped in attempts to bracket her own views, and to counter researcher bias. These elements of the study served to enhance the validity of this phase, thus contributing to credibility and rigour.

The second phase of this research drew participants from the 53% of SLTs who were found to have poor biopsychosocial well-being. While the first phase of the research identified how well-designed psychosocial SLT work environments were associated with better well-being, these environments were not further explored, and the lived experience of SLTs who work in these environments was not investigated. However, those interviewed did report elements of good practice that may be shared.

This sample represented the white female-dominated profession. However, a limitation of the qualitative phase of the research is that no men were interviewed. This was despite an attempt to include men in the sample. Although three men had agreed to be interviewed, attempts to contact them proved futile. However, one person from a Black, Asian and Minority Ethnic community was interviewed.

A further limitation of Phase Two was that participant checking of the information that they had provided was limited. Although they were sent summaries of the interviews, interpretation of the data was not shared. However, this is not necessary in IPA (Smith, et al, 2009) and, if done, could have meant that additional demands were made on participants.

11.6 Concluding Remarks

Results of this study indicate that just over one in two SLTs working clinically in the UK at the current time are at risk of being psychologically vulnerable to anxiety, depression, experiencing somatic symptoms of stress and social dysfunction. This is a worrying statistic which has possible implications for SLT career longevity. Data was collected before the onset of COVID-19, suggesting that there were psychological health issues in the workforce before the current pandemic commenced.

Findings of this research suggested that SLTs with little control over high demands, and with low support (i.e., IsoStrain jobs) had the lowest job satisfaction and were most at risk of mental health problems. An IsoStrain job for an SLT included an excessive workload, with a caseload that was perceived to be unmanageable and a lack of autonomy regarding how that caseload was managed, both in terms of numbers, but also with regards to dosage and course of treatment. Clinical supervision was sometimes absent or ineffective, and strong support for the emotional demands of the job was not provided. Finally, SLTs may feel undervalued by managers, other professionals, commissioners and/or the general public. Findings are generally aligned with previous research that has been conducted in other countries and provide new and up-to-date information for UK SLTs specifically.

Although some stakeholders consider psychosocial risks difficult to address in a preventative fashion, focusing on opportunities and resources is necessary in order to mitigate risk (Leka, et al., 2015). Findings of this study demonstrate the need for holistic appraisal of SLT job design, which must include input from front-line practitioners. This should determine whether the design of jobs requires addressing. Consideration of job design necessitates a nationwide review of caseload sizes and staffing, and should include the development of support and supervision, possibly utilizing new ways of working that have emerged during COVID-19, and drawing on good practice both from within the NHS, outside of it and in the self-employed sector. The RCSLT has a role to play, in promoting understanding of the profession, in developing their guidance on support and supervision, and in considering how this guidance is used by practising clinicians.

Finally, this research is a first step in the attempt to understand and support the well-being of SLTs in the UK. It is a snapshot of their lives and as such, given the findings, it is the ethical responsibility of researchers to continue to study this neglected area in order to assist in attempts to ensure that psychosocial risks are managed, and hazards are remedied.

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Appendix A1

Musculoskeletal Disorders and Cardiovascular Disease

Musculoskeletal Disorders (MSK)

Stress and MSKs are the two biggest causes of work-related ill health in the UK (Lawson, 2016). The link between stress and MSKs is not straightforward. It is not simply that people who have increased physical demands placed upon them experience more MSKs. On the one hand, certain types of MSKs may be a direct physiological response to an environmental hazard such as ergonomic aspects of the workplace. Injury can be caused by a badly designed workstation, limited (or excessive) movement, lengthy screen time without a break, poor posture, or poor techniques for lifting or carrying heavy objects (Cox & Jackson, 2005, Black & Frost, 2011a). On the other hand, the underlying pathophysiology of chronic pain shares a common neurobiology with psychiatric disorders, and both a have a 'shared mechanism for symptom manifestation' (McFarlane, 2007, p556). This effectively means that stress and MSKs are related. MSKs have been linked to factors that contribute to stress: monotonous work, perceived high workload, lack of control, lack of social support and time pressures (Smedley, Dick & Sadhra, 2013).

The South Manchester Back Pain Study, which employed a cross-sectional survey with a follow-up after twelve months, revealed that the risk of reporting lower back pain doubled in those who were dissatisfied with their work. In addition, the association between job dissatisfaction and lower back pain was not explained by general psychological distress (Papageorgiou et al., 1997).

Devereux, Buckle, & Vlachonikolis (1999) found that both physical factors (such as poor ergonomics, or the requirement for manual handling) and psychosocial factors (including high mental demands, low control and a lack of social support) independently increase the risk of self-reported back disorders (including aches, pains and discomfort). They also reported that this risk is exacerbated by the interaction between physical factors and psychosocial factors. In addition, Zeytinoglu, Denton, & Davies (2009) reported that stress and perceptions of workplace insecurity were both positively associated with MSKs. In a longitudinal study investigating the effects of effort-reward imbalance on the health of childcare workers in Germany, Koch et al. (2017) used the Nordic questionnaire to

investigate the prevalence of MSKs. They found significant associations between and ERI and MSKs, with symptoms occurring in the back, in the neck and a combination of neck, back and shoulders.

Turning to health professionals specifically, Feyer et al. (2000), in a three-year longitudinal study of nursing students, found that new episodes of lower back pain followed increased periods of distress (as measured by the General Health Questionnaire–28). Work-related MSKs have also been found to be associated with job stress in occupational therapists (Park & Park, 2017).

Finally, MSKs can be related to affective outcomes, for example prolonged back pain can result in anxiety and depression (Black, 2008).

Cardiovascular disease (CVD)

Both the JDC model (Karasek & Theorell, 1990) and the ERI model (Siegrist, 1996) were used to measure the risk of coronary heart disease in a longitudinal study of Finnish workers by Kivimäki et al. (2002). The authors demonstrated that individuals with high job strain and an effort-reward imbalance experienced an increased risk of cardiovascular mortality. Including only participants who were free from heart disease at the beginning of the study, and after adjusting for sex and age and baseline values, they also found that workers with a high effort-reward imbalance and low control had increased body mass index. Finally, employees with high job strain and low control had increased concentrations of total cholesterol. These findings were corroborated by Kuper et al. in (2002), whose report was based on data from the longitudinal Whitehall II study, that spanned 11 years. The health of non-industrial civil servants working across twenty departments in London was investigated, with findings revealing that an effort-reward imbalance predicted an increased incidence of both non-fatal and fatal coronary heart disease. Preckel, Meinel, Kudielka, Haug, and Fischer (2007) found similar results in their study of workers in the aircraft manufacturing industry in southern Germany, where both an imbalance in effort and reward and the individual factors themselves (i.e. the influence of effort alone, or of reward alone) were associated with 'vital exhaustion', a state which they describe as being characterized by unusual levels of irritability and fatigue, and feeling demoralized, and which is a risk factor for CVD.

The above studies all used self-assessment to ascertain levels of demand and control. Perception has been shown to be important when considering decision latitude, as demonstrated in an experimental study conducted by Steptoe, Evans, and Fieldman, in 1997. In laboratory conditions, utilizing a between-subject design, demand was controlled for, but one group completed tasks under external pacing, whereas the other were self-paced. Those in the externally paced group attempted more problems during the task, made more errors and had heightened systolic blood pressure responses, compared to the self-paced group. Of significance is that the pacing was not set through direct time constraints, but by the manipulation of instructions i.e., participants were told what level of performance they might achieve. This led the authors to conclude that information about performance expectations was enough to induce perceptions of time pressure and that this then corresponded to increases in physiological activation. This is important, as it supports findings that use self-report, i.e., cardiovascular changes are in response to perception of control, which is more important that an actual level of control.

In addition to job strain itself, behavioural responses to stress are also coronary risk factors (Kuper et al., 2002). These responses include smoking (McVicar, 2003), drinking (Harvey et al., 2009; Nakao, 2010) and overeating (J. R. Edwards, Caplan, & Harrison, 1998) and are all behaviours which can be classified as emotion-based coping strategies (McVicar, 2003). Although employed in an attempt to alleviate stress (Cardon & Patel, 2013), they ultimately exacerbate the link between job strain and CVD (McVicar, 2003).

Appendix B1

Ewen, C., Jenkins, H., Jackson, C., Jutley-Neilson, J. & Galvin. J. (2020). Well-being, job satisfaction, stress and burnout in speech-language pathologists: A review. *International Journal of Speech-Language Pathology*, Early online, 1-11. https://doi.org/10.1080/17549507.2020.1758210

Abstract

Purpose: The purpose of this review was to evaluate the factors that influence well-being, job satisfaction, stress, and burnout in speech-language pathologists (SLPs), and to identify the impact of these variables on worker recruitment and retention.

Method: A systematic literature search was conducted. Four electronic databases (PsycARTICLES & PsycINFO, PubMed/Medline, CINHAL and ABI/INFORM) were searched. The search was limited to articles published in English between 1998 and June 2018. To be eligible for inclusion, studies needed to investigate or report well-being, job satisfaction, stress or burnout in SLPs. The methodological quality of each paper was assessed using the "Strengthening the Reporting of Observational Studies in Epidemiology" (for quantitative data) and "Consolidated criteria for Reporting Qualitative research" (for qualitative data) checklists. A data-driven thematic analysis of the literature was used to identify key themes.

Result: Seventeen of 2050 studies met the inclusion criteria, of which fifteen were cross-sectional surveys yielding quantitative data. Two were qualitative studies. There was consistent evidence for SLPs in the USA and Canada experiencing satisfaction in their jobs. Facet analysis of job satisfaction, stress and burnout revealed six contributory themes, three of which were clearly associated with well-being: workload/caseload size, professional support, and salary. The contribution of job control (autonomy), length of time in practice and work setting was inconclusive. Evidence for stress and dissatisfaction leading to workforce attrition was found.

Conclusion: Job satisfaction, stress, and burnout were found to be associated with various occupational features, including elements of demand, support and reward. No previous studies have investigated the interaction between different elements of a job, which might boost satisfaction or ameliorate stress in SLPs. This is the first review using a systematic approach to focus on job satisfaction, stress and burnout in SLPs and suggests more work needs to be done to help identify and improve the well-being and satisfaction of the workforce.

Introduction

Evidence suggests that healthy workers are productive workers and that the cost to a nation when the workforce is unwell, is significant (Black, 2008; Hartshorne, 2006; Cox & Jackson, 2005). In the case of Speech-Language Pathologists (SLPs), this cost arises on two fronts: both with regards to a healthy, productive workforce and with respect to the societal impact that a lack of services due to an unproductive or unwell workforce has on the well-being of children, young people and adults with communication and swallowing difficulties (Hartshorne, 2006).

Subjective well-being (SWB) refers to the cognitive and affective evaluations that people make about how well they feel (Wright, Cropanzano, & Bonett, 2007). It is an inclusive term and is used to refer to happiness, positive affect, the absence of negative affect, and life satisfaction (Bowling, Eschleman, & Wang, 2010). Measures of SWB have been associated with measures of job satisfaction (Waddell & Burton, 2006), a construct which includes receiving recognition for a job well done, feeling close to people at work and receiving fair wages (Macdonald & MacIntyre, 1997). The correlation between job satisfaction and performance is well documented, as is the negative effect of stress on an individual's ability to do their job well (Callaghan & Coldwell, 2014).

Stress or "distress" is the emotional strain/tension that results from adverse, unwanted or unmanageable circumstances (Cooper, Dewe, & O'Driscoll, 2001). The Job Demand Control Support (JDCS) model (Johnson & Hall, 1988; Karasek, 1979) has been used extensively to investigate the stress that may result from occupational experiences (Hausser, Mojzisch, Niesel, & Shulz-Hardt, 2010; Van der Doef & Maes, 1999). The model describes the demand (e.g. workload), control (e.g. levels of

autonomy) and professional support (e.g. from managers and colleagues) that contribute to stress.

Described as an extreme form of occupational stress, (Cooper et al., 2001), "burnout" is experienced particularly by those working in the helping professions. It was characterised in 1981 by Maslach and Jackson as including emotional exhaustion, depersonalisation and feelings of reduced personal accomplishment. This classification was updated by the World Health Organisation in 2018, to include 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) reduced professional efficacy. The consequences of high levels of stress and burnout include physiological responses e.g. headache, musculoskeletal disorders, heart disease (Cox & Jackson, 2005) and psychological responses e.g. anxiety, depression (Fernandes & Da Rocha, 2009). Stress and burnout can have behavioural responses, including absenteeism, difficulties recruiting and a higher turnover of staff (Denham & Shaddock, 2004; Gallego, et al., 2015; Leka, Griffiths, & Cox, 2004).

The professional occupations, including those in the health sector, experience more stress than any other (Health and Safety Executive, 2015; Office for National Statistics, 2017). While the stressors for other healthcare professionals such as doctors and nurses are well documented (McVicar, 2003; van Doorn, van Russeveldt, van Dam, Mistiaen, & Nicolova, 2016), less is known about the workplace health of SLPs. For this reason, this review focused on the job satisfaction, stress and burnout of SLPs.

The review questions were:

5. Are SLPs satisfied with their jobs?
6. What levels of stress or burnout do SLPs experience in their jobs?

7. What are the work factors that are associated with SLP job satisfaction and stress/burnout?
8. What are the effects of job satisfaction and stress/burnout on recruitment and retention?

Method

Search Strategy

Four electronic databases (PsycARTICLES & PsycINFO, PubMed/Medline, CINHAL and ABI/INFORM) were methodically searched for peer-reviewed articles published between 1998 and June 2018 and written in English. Search terms were categorised into two groups: (a) population, (b) occupational health. The first group included variants on the professional title of SLPs: "speech and language pathologist", "speech pathologist", "speech and language therapist", and "speech therapist". Because SLPs are sometimes included in studies that investigate allied health professionals (AHPs), key words also included the terms "allied health professionals" and "rehabilitation professionals". The second group included terms used to describe the occupational health of workers: "well-being", "job satisfaction", "stress", and "burnout". Selection of the terms in this group was based on terminology that is commonly used within the field of occupational health to operationalise well-being at work. First, terms from the first group were entered using the Boolean operator OR e.g. "speech and language therapist" OR "speech and language pathologist", then the same procedure was used with terms from the second group e.g. "stress" OR "burnout". Finally, the results from the first two searches were combined with the Boolean operator AND e.g. results of "speech and language therapist" OR "speech and language pathologist" AND results of "stress" OR "burnout" (Supplementary

Appendix 1). Supplementary to this search strategy, the reference lists of articles located were used to source any additional, relevant articles.

Selection of Studies

To be eligible for selection, the following criteria needed to be met: Papers were required to be empirical studies that reported primary research data that included information on either: 1) the well-being, job satisfaction, stress or burnout of SLPs, or 2) the well-being, job satisfaction, stress or burnout of AHPs where SLPs were included, mentioned explicitly in the analysis and reported on separately to other AHPs within the participant group. No restrictions were placed on study design, as this search aimed to be as inclusive as possible.

Quality Assessment

The quality of papers presenting quantitative data was assessed using an adaptation of the “Strengthening the Reporting of Observational Studies in Epidemiology” (STROBE) recommendations (Vandenbroucke et al., 2014). Adaptation was necessary, because although the articles reviewed could be classified as epidemiological, the STROBE guidelines were developed for use in medical research. The quality and credibility of papers presenting qualitative data were assessed using the “Consolidated criteria for Reporting Qualitative research” (COREQ) checklist (Tong, Sainsbury & Craig, 2007). Mixed methods papers that produced both types of data were assessed under both sets of criteria.

Data analysis and evidence synthesis

Disparate study designs and approaches to data analysis prevented the use of meta-analysis. To enable the synthesis of the findings of the search, a data-driven thematic analysis of findings was conducted (Dixon-Woods, Agarwal, Jones, Young &

Sutton, 2005). The aim of this was to facilitate a fully inclusive review of findings. One author (CE) used open coding techniques to identify major themes.

Although "well-being" was entered as a search term, no studies explicitly included the construct as an outcome. The three remaining constructs (job satisfaction, stress and burnout) were analysed as follows: Firstly, the presence or absence and level of the construct reported was examined. Secondly, the factors associated with these concepts were classified into themes. Themes were included if they appeared in three or more studies.

Result

Literature search

The search yielded 2050 papers. Duplicates (640) were removed, after which the titles and/or abstracts of the remaining 1410 articles were reviewed for relevance. This resulted in 25 studies being identified. The inclusion criteria were then applied to the full text of these studies, after which 15 papers remained. The main reason leading to the exclusion of full text articles was the failure to separate SLP data from the other AHPs in the study. One study was excluded because the investigation specifically reported satisfaction with elements particular to a location i.e. the structure and functioning of newly established Family Health Support Centres in Brazil (Molini-Avejonas, Aboboreira, Couto & Samelli, 2014). Two publications were added after reference checking, bringing the total number of papers reviewed to 17. The process for the inclusion of studies in the review can be found in Figure 1.

Figure 1: Flowchart of the inclusion process of articles reviewed

Studies included

Of the seventeen papers that were sourced, eight studies took place in the USA, three were carried out in Australia and two in the UK. One study took place in Canada, one in Italy, one in Iran, and one in South Africa. Descriptions of the study location, population, design, area investigated, measurement method and results are summarised in a data extraction table (Table I).

Three study designs were present within the literature: thirteen consisted of cross-sectional surveys that yielded quantitative data. Two were mixed-methods studies, where qualitative and quantitative data was gathered as part of large-scale cross-sectional surveys. Of these, one paper (Loan-Clarke, Arnold, Coombs, Bosley & Martin, 2009) only reported their qualitative findings, which they then quantified (the quantitative element of the study was reported elsewhere and did not separate out SLPs). Finally, two used qualitative designs.

Participant numbers ranged from 23 to 1207 in the cross-sectional surveys (reported response rates ranged from 19.6% to 71.2%). One mixed methods study had 293 participants and the other had 516. Seven participants were interviewed in one of the qualitative studies, and eighteen were interviewed in the other.

All studies included in the review reported the job satisfaction, stress/stressors, or burnout experienced by SLPs. These constructs were sometimes considered to be predictors of outcomes (e.g. job satisfaction predicting retention), and sometimes as outcomes (e.g. stress as the outcome of lack of support).

A variety of scales were used in the cross-sectional studies to measure job satisfaction, stress or burnout. Six of the fifteen studies that gathered quantitative data used questionnaires that were designed by the authors. The Speech-Language Pathologist Stress Inventory (SLPSI; Fimian, Lieberman, & Fastenau, 1991), the Job

Satisfaction Survey (JSS, Spector, 1997), the Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985) and the Maslach Burnout Inventory (MBI, Maslach, Jackson & Leiter, 1996) were all used twice. In addition, five other published scales were used (see Table I). Statistical analysis included inferential tests and structural equation modelling, some studies limited their analysis to descriptive statistics, and not all provided central tendency data. The two mixed methods studies used content analysis to explore open-ended items, with one of these (Loan-Clarke et al, 2009) quantifying the data to perform frequency distribution analysis. One qualitative study identified themes within the data collected from interviews, which they then coded; the other used phenomenological analysis to interpret findings.

Quality appraisal

The fifteen studies yielding quantitative data were assessed using the STROBE statements. Of these, twelve included sixteen or more of the possible twenty-three criteria. One contained thirteen criteria, one contained twelve, and one contained eleven criteria. The majority of the quantitative papers included the following methodological strengths: the study objectives, sources and methods of recruitment, variables under investigation and data sources/measurement were clearly described and appropriate. The methodological criteria least often included was bias, with only two studies discussing the attempt to deal with possible bias (in the measurement instruments). Only two studies included information about how the sample size was reached (funding restrictions) but none mentioned the determination of sample size with regard to statistical analysis (e.g. through power analysis), although one did state that the final numbers of participants was sufficient for sound statistical analysis. The reporting of results was variable, with descriptive statistics more commonly provided

and fewer studies engaging in further analysis. Two papers provided effect sizes. The quality appraisal for the papers reporting quantitative data can be found in Table II.

The four papers presenting qualitative data were assessed using the COREQ criteria. For the two qualitative studies which conducted interviews, one study met seventeen of the thirty-two criteria. Not all items were applicable to the second study, which met eleven of the thirty that were germane. For both, the protocol was provided, sampling methods were described, and themes were clearly presented and supported with quotations from participants. Credibility was achieved for both papers through clear reporting of methods and consistency between data and results (Silverman, 2011). However, neither paper provided information about the research team and its reflexivity (although Warden, Mayers & Kathard, [2008] did include the gender and occupation of the interviewer), about how the final sample size was reached (e.g. whether the need for, or relevance of saturation was considered), or whether participant checking (i.e. participants providing feedback on findings) took place. Only one (Warden et al., 2008) stated the methodological orientation that underpinned the study. The two mixed methods papers that gathered qualitative data through large-scale surveys (Heritage, Quail & Cocks, 2018; Loan-Clarke, et al., 2009) did not lend themselves well to the COREQ criteria, with some items being irrelevant. Of the fourteen criteria that were relevant to both, nine were met in each case. Both presented themes clearly, but the Loan-Clarke et al. (2009) study provided only one example of a question asked and did not include participant quotations. This resulted in a lack of transparency regarding consistency between data and findings, meaning credibility was potentially threatened. The quality checklist for the four papers reporting qualitative results can be found in Table III.

Findings of the review:

Level of well-being

Only one study reported well-being as a specific construct under investigation. Using A Shortened Stress Evaluation Tool (ASSET), McLaughlin, Adamson, Lincoln, Pallant and Cooper (2010) investigated well-being as a predictor of intent to leave a job or the profession. The ASSET psychological well-being mean score was not provided, meaning it is not possible to comment on the level of well-being for participants in their study. The remaining studies specifically investigated job satisfaction, stress (or stressors) and/or burnout. These terms were not used to operationalise well-being as a construct, although well-being was sometimes used as a general term in discussion sections.

Level of job satisfaction

The level of job satisfaction in SLPs was reported in seven studies. Hutchins, Howard, Preclock and Belin (2010) reported "high degrees" of satisfaction, based on the overall mean of a self-designed questionnaire. Blood, Ridenour, Thomas, Dean-Qualls and Scheffner-Hammer (2002b), found that clinicians working in state schools in the USA had average job satisfaction scores on the JSS (i.e. mean score of 126.8 within one SD of the expected mean score of 136.5). The JSS was also used by Kalkhoff and Collins (2012), at which time SLPs in the USA scored significantly higher (M=147.3, SD=29.5) than the norm for the average American worker (M=136.5, SD=12.1) on overall job satisfaction. Moreover, 50 respondents (51%) in this study had high satisfaction (individual mean scores >1SD above the JSS mean) and 31 (32%) had average job satisfaction (individual mean score within one SD of the mean). A UK study by Cox and Cruice (2010) reported that 27% of overseas-trained SLPs were satisfied with waiting lists, 30% with caseload size, 30% with status, and 52%

with salary. Loan-Clarke et al. (2009) reported that 13% of their participants cited job satisfaction as a reason to remain working in the National Health Service (NHS) in the UK.

Edgar and Rosa-Lugo (2007) asked participants working in public schools in the USA to rate how strongly they “favoured” 24 different elements of their jobs. They concluded that the five areas which had the most satisfaction included working with children (74%), school schedule (54%), school hours (45%), school assignment (41%) and the availability of an experienced mentor (41%). The four areas where most dissatisfaction was reported were overwhelming workloads (44%), the role of the SLP being misunderstood (41%), salary (40%), and large caseloads (35%).

Kaegi, Svitch, Chambers, Bakker and Schneider (2002) compared a sample of 56 clinicians working in Canada across three locations: rural Alberta (n=29), urban Alberta (n=18) and Ontario (n=9). There were significant differences in the length of time in the job across groups, with those who had worked longer (clinicians in Ontario) being less satisfied. The authors found that 66% of the clinicians working in rural Alberta, 72% of those employed in urban Alberta and 12% working in Ontario were satisfied with their jobs. Despite apparent differences between groups, when length of time worked was used as a covariate in analysis no significant differences in satisfaction were found between them.

Level of stress and burnout

While burnout is specifically conceptualised using the three dimensions mentioned previously, and therefore might be viewed as a separate construct to stress, the World Health Organisation (2018) defines it as a ‘syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed’. Stress and burnout were therefore considered together. Three studies identified in the

review investigated stress and three reported on burnout. Three studies reported the relationship between stress and behavioural responses in participants and one of the qualitative studies identified burnout in their themes.

One of the three papers investigating stress (Blood et al., 2002c) compared stress levels of participants to an earlier study (Fimian et al., 1991). In both studies, respondents completed the SLPSI, a measurement tool specifically designed to investigate the effect on stress levels of particular stressors for SLPs. Participants who completed the SLPSI in the 2002 study were reported as having “barely noticeable” stress when compared to the original 1991 sample. However, no statistical test to determine significance was reported. Harris et al. (2009) found that state school clinicians in Utah, who also completed the SLPSI, had significantly less stress than the original sample.

Blood, Blood, Scheffner-Hammer and Dean-Qualls (2002a), using the Health Profession Stress Inventory (HPSI), compared their findings to normative means for nurses (M=61.2), pharmacists (M=56.0) and general physicians (M=46.9) and found that SLPs working in US healthcare had ‘comparatively low’ levels of stress (M=48.5). Once again, significance testing was not reported by the authors.

Burnout in Iranian SLPs was investigated by Kasbi et al. (2018). Of the 182 participants in the study, 99.7% reported some level of burnout (44% had mild burnout, 53.5% moderate burnout, and 2.2% severe burnout). Kaegi et al.’s 2002 questionnaire included the statement, “I suffer from burnout”, to which 79 (51%) respondents agreed or strongly agreed. In a study of Italian AHPs, Bruschini, Carli and Burla (2018) found that 10% of SLPs were at risk of burnout. They defined ‘burnout risk’ as having high scores on the Emotional Exhaustion and Depersonalisation subscales of the MBI, and low scores on the Personal Accomplishment subscale. The AHP data (which included

the SLPs) showed that 32% were experiencing high levels of emotional exhaustion, 13% depersonalisation and 9% reduced personal accomplishment. No statistically significant differences were found between the different groups of AHPs.

One qualitative study added to the literature on burnout. McLaughlin et al. (2008) identified feelings of decreased personal accomplishment (one element of burnout) in their interviewees, which led them to conclude that the SLPs were possibly at risk of developing burnout.

Job factors associated with job satisfaction, stress and burnout

Studies explored a variety of factors that might contribute to job satisfaction or stress/burnout. Examples of findings include the achievement of a balance between work and home predicting job satisfaction (Smith-Randolph & Johnson, 2005), a lack of correlation between educational qualification and job satisfaction (Blood et al., 2002) and no relation between distance travelled to work and risk of burnout (Bruschini et al., 2018). However, the weight of evidence pointed toward workload/caseload (demand), control, support, work setting, and salary as important factors associated with the outcomes, with three or more studies reporting on these factors (although not always being reported as a specific objective of the study). These factors were therefore considered as themes for the purpose of structuring this section of the review.

Workload and/or caseload size

Satisfaction with workload or caseload size was the most frequently cited factor, with thirteen of the papers including findings about this element of the job. In the USA, studies on the relationship between job satisfaction and workload and/or caseload size have described varied results. Blood, et al. (2002b) identified a significant negative correlation between caseload size and job satisfaction for SLPs. Smith-Randolph and

Johnson (2005) found that a “realistic” workload was a predictor of job satisfaction and Edgar and Rosa-Lugo (2007) reported that 34.6% of their 382 participants were dissatisfied with caseload size and 44.2% were dissatisfied with workload.

Hutchins, et al. (2010) reported that while SLPs were generally satisfied with their jobs, there was a significant relationship between caseload size and workload satisfaction specifically. The perception of a high caseload was associated with increased stress in Harris et al.’s study in 2009; and Blood, et al., (2002c) described overwork and large caseloads as “chronic” stressors for school-based SLPs. However, Blood et al. (2002a) found no statistical relationship between caseload size and stress. Finally, Kalkhoff & Collins (2012) argued that job satisfaction was not predicted by caseload size but no statistical information to support this claim was provided.

Studies from countries outside of the US are not as plentiful. Kaegi et al. (2002) reported a negative association between caseload size and satisfaction in Canadian SLPs. In Cocks and Cruice’s (2010) study of overseas-trained clinicians working in the UK, 30% of their 23 participants reported larger UK caseload sizes compared to those in their home country, and this was linked to job dissatisfaction. Cross-tabulation analysis of this small sample revealed that of the participants who were dissatisfied, all had larger caseloads than they had in their home country. In contrast, while Bruschini et al. (2018) did not comment on workload specifically, they did investigate demands using the Health and Safety Executive’s (HSE’s) Management Standards Indicator Tool. No significant correlations were found between demand (which included workload) and burnout risk.

Data from qualitative enquiries supplemented the statistical information. Workload was the main source of stress for SLPs interviewed in Australia (McLaughlin,

Lincoln & Adamson, 2008), and in the UK, Loan-Clarke et al. (2009) reported that over 20% of participants reported excessive workloads.

Control/Autonomy

Due to the subjective nature of some of the reporting and the scarcity of correlational data, the evidence for job control and its relationship to stress in SLPs is inconclusive. Only one study specifically stated the investigation of control as an objective. Bruschini et al. (2018) found that a lack of control, as measured by the HSE Management Standards Indicator Tool (e.g. having the ability to make choices over how work is completed), was associated with a risk of burnout. Four other quantitative studies included some elements of control in their questionnaires, and both qualitative papers mentioned it.

Harris et al. (2009) reported that the Bureaucratic Restrictions subscale of the SLPSI – which contains some items that measure control - was strongly correlated ($r>0.79$) with stress scores i.e. dissatisfaction with bureaucratic restrictions was correlated with higher stress. Blood, et al. (2002a) found that clinicians working in healthcare reported being able to participate in making decisions about their jobs, were able to use their abilities to the fullest extent during their jobs, and knew what type of job performance was expected. Clinicians therefore appeared to have adequate levels of control over occupational demands, resulting in low levels of stress around autonomy. Similarly, a lack of control over service delivery was not reported as a stressor for the school-based SLPs in Blood et al.'s (2002c) study, in which stress was "barely noticeable".

Kaegi et al., (2002) found that the large majority of SLPs in their study had "enough authority to do their job" whereas, while interviewing clinicians, McLaughlin et al. (2008) identified stress in SLPs that was due to a lack of autonomy. Warden et

al (2008) reported that SLPs struggled to gain the same level of control when working in comparison to when they were student practitioners. However, they did not comment on whether this affected their job satisfaction or stress.

Professional support

Professional support (or the lack thereof) featured in seven studies. Three identified the contribution of a lack of support to stress or burnout, one linked support to job satisfaction, one reported that support was perceived to mediate stress, one described satisfaction with the support SLPs received, and the last mentioned sources of support for SLPs.

Harris et al. (2009) found that a lack of professional support accounted most strongly for an increase in stress and Bruschini et al. (2018) found that poor support from management was associated with an increased risk of burnout, but support from colleagues (e.g. strong team relationships) protected against burnout. Blood et al. (2002c) reported that little interaction with peers and supervisors as well as low functional support (i.e. support from family) predicted higher levels of stress. Smith-Randolph and Johnson (2005) reported that the presence of adequate support staff predicted job satisfaction. Kaegi et al. (2002) found that 64.5% of the 47 SLPs in Alberta and 33% of the nine in Ontario were satisfied with the help received from supervisors and were also satisfied with their jobs. When interviewed, clinicians in Australia identified support as mediating stress (McLaughlin et al., 2008) and SLPs in South Africa cited the multidisciplinary team and administrative colleagues as sources of support (Warden et al., 2008). The available data therefore implies that a lack of support contributes to dissatisfaction and stress/burnout in SLPs.

Work setting

Four quantitative studies reported on the differences between groups: three compared rural to urban settings and one contrasted SLPs working in schools with those employed in medical settings. In addition, one qualitative paper mentioned work setting as a source of job satisfaction.

No difference in stress between rural and urban settings was found by the three studies that compared these groups of clinicians (Blood, et al., 2002c; Blood, et al., 2002b; Harris, et al., 2009). Kalkhoff and Collins (2012) compared clinicians working in schools across the USA to those working in medical settings and reported that those employed in medical settings were significantly more satisfied generally than those employed in schools. Specifically, SLPs in medical settings were significantly more satisfied with promotion, contingent awards, operating conditions, and co-workers. Finally, clinicians interviewed by Warden et al. (2008) reported that they found working in a teaching hospital environment to be a source of job satisfaction.

Length of time in practice

Length of time working was reported in five papers. Kaegi et al (2002) identified a negative association between job satisfaction and the length of time working for school-based SLPs. Contrastingly, Blood, et al. (2002b) reported that increasing number of years in a job was a predictor of increasing job satisfaction for school-based SLPs in their study. Blood, et al. (2002a) also reported significant correlations between lower stress and years at the current job, with those who had been working longer reporting lower levels of stress. Bruschini et al. (2018) found no significant correlation between the length of time worked and the risk of burnout, and Kalkhoff and Collins (2012) reported no significant relationship between the length of time an SLP had been in their current job and their job satisfaction.

Salary

Seven studies included salary as a factor that contributed to job satisfaction or stress. Blood et al. (2002c) found that an "inadequate salary" featured in the top eleven sources of stress for school based SLPs, with 33% of participants reporting it as a perceived stressor. Forty percent of the 382 participants in Edgar and Rosa-Lugo's (2007) study were dissatisfied with their salaries and Blood et al. (2002b) reported that SLPs in their sample had low satisfaction with pay. SLPs working in healthcare also reported feeling that they were inadequately paid (Blood 2002a), and half of the 23 clinicians surveyed by Cocks & Cruice (2010) were dissatisfied with their salary. Unhappiness with salary was also associated with an increase in stress in the study by Harris et al. (2009). Smith-Randolph and Johnson (2005) stated in their abstract, discussion and conclusion sections that "intrinsic factors such as competitive pay" were weaker in significance for predicting career satisfaction and desire to stay in the job. However, there was nothing in the results section that specifically mentioned this. Overall, findings do suggest a link between perceived incommensurate salary and job dissatisfaction and stress/burnout.

The effect of SLP job satisfaction, stress/stressors and burnout on recruitment and retention

The main effect of job satisfaction, stress/stressors and burnout which has been investigated over the last twenty years, is worker movement. The effects of job satisfaction and/or stress/stressors on recruitment and retention were reported in five studies. Analysing responses to open-ended items on a questionnaire, Loan-Clarke et al. (2009) reported that 13% (n=310) of participants cited job satisfaction/enjoyable or interesting work as a reason to remain working in the National Health Service (NHS) in the UK. Conversely, 7.5% (n=110) stated that job satisfaction in their new place of

work meant that leaving the NHS had been the right thing to do. They also reported that 6.8% (n=162) of their participants described specific stressful events as a reason to "seriously think about leaving" the NHS, 20.2% (n=109) left the NHS due to stress, and 13.3% felt that stress reduction was an action that could be taken by NHS management to increase the chance that they would remain in or return to the NHS.

Heritage et al. (2018) reported that a lack of job satisfaction contributed significantly to the intention to leave the profession. In addition, their qualitative content analysis identified elements of job satisfaction which encouraged participants to stay in their current position (e.g. the fulfilling nature of the job) and revealed that workload-related stress was related to SLPs' decision to attempt to find a different position.

Dissatisfaction with workload was identified to have the biggest impact on retention (i.e. remaining in a current position) by Edgar and Rosa-Lugo (2007), and dissatisfaction with salary interacted with both retention and longevity. Finally, clinicians interviewed by McLaughlin et al. (2008) made connections between job satisfaction, stress, barriers to clinical effectiveness and leaving their current position.

Finally, McLaughlin et al. (2010) investigated SLP intention to leave their job and the profession. While the authors did not comment on stress levels per se, they did identify particular stressors which predicted intention to leave. Low job security predicted intent to leave a job and spending more than 50% of one's time on administrative duties predicted intent to leave the profession. Scoring low on the 'positives of the profession' e.g. not having professional needs met, predicted both intent to leave the job and intent to leave the profession. A low score on the ASSET psychological well-being score did not predict intent to leave the job or leave the profession. Participants who achieved a higher negative affect score as measured by

the Positive and Negative Affect Scale (PANAS) were more likely to leave the profession.

Discussion

The objective of this review was to investigate the current status of SLPs, with respect to well-being, job satisfaction, stress and burnout, and to explore factors associated with, and the effect of, these outcomes. Evidence in the data for the presence and levels of job satisfaction and stress/burnout, the contributory elements of a job to these constructs, and their impact, was integrated.

Comparison of findings is problematic, due to differing methodologies and a variety of study foci. Context varied widely and inclusion of statistical reporting was mixed, with some studies concentrating on descriptive measures and others using inferential tests. However, it was possible to identify certain themes, facilitating a review that used the principles of a systematic review, but is thematic in nature (Dixon-Woods, et al., 2005).

The review revealed high levels of job satisfaction for SLPs in the USA and Canada. The data regarding stress and burnout is less conclusive. Studies did not provide compelling evidence for the presence of high levels of negative stress, and there were conflicting reports about the presence of burnout. However, papers reporting on retention and recruitment identified stress as one of the reasons that SLPs leave their jobs.

In the studies reviewed, there did not appear to be strong links between methodology and interpretation of findings; and established theories of occupational health at work. For example, three themes related to the Job Demand Control Support model (Johnson & Hall, 1988; Karasek, 1979), yet no individual study adopted or even mentioned this framework. The JDCS model has been used extensively in research

investigating the biopsychosocial work experience (Hausser et al., 2010) and could potentially be applied to the SLP workforce in the future. The main way of operationalising demand in the identified studies was to consider workload or caseload size. The review found consistent evidence that excessive workloads and/or caseloads are correlated with a lack of satisfaction and an increase in stress and burnout. Evidence was also found for a relationship between a lack of control and higher stress/burnout, but no study focused on the relationship between control and job satisfaction. A lack of professional support appeared to be correlated with both stress/burnout and job dissatisfaction.

The evidence for the remaining three themes was variable. The link between perceived inadequate salary and dissatisfaction and/or stress appears to have been confirmed, but there was mixed evidence regarding the impact of the length of time worked, and limited evidence with regards to the role of work setting, with only one study finding that SLPs working in medical settings in the USA were more satisfied than those working in schools. Future work is necessary to determine the impact of these variables on SLPs job satisfaction, stress and burnout.

Several studies investigated recruitment and retention in the profession. While attention on recruitment/retention is necessary for influencing policy and practice, there has been scant attention paid to the mental health of SLPs as a workforce. This review identified that job satisfaction, stress and burnout are important considerations for healthcare organisations aiming to improve recruitment and retention of staff.

Methodological issues

Several methodological shortcomings were identified in this research area. Firstly, study design was restricted to cross-sectional surveys and there are no longitudinal studies on the topic. The paucity of qualitative studies means that there is

meagre rich, in-depth data that might offer an insight into the lived experiences of SLPs. A further methodological restriction involved the measurement of job satisfaction. Almost half the papers reported using self-designed questionnaires and in no instances was construct validity discussed. Moreover, the determination of sample size received scant attention. Studies did not always include information that allowed for meaningful comparison between, for example, the sample and pre-established norms. In addition, only two studies provided effect sizes.

Strengths and limitations of the review

This is the first review that has aimed to synthesise research about the occupational well-being of speech-language pathologists. A strength of the review is its broad approach, that enabled the synopsis of information sourced from a disparate body of literature. The dissimilar nature of the studies resulted in the inability to determine the strength of evidence for the themes identified, which might be viewed as a limitation of the review. However, the presentation of the data provides insight into some aspects of the well-being of SLPs, as well as the causes for and effects of job satisfaction and stress/burnout in this workforce.

As in every review, bias may have occurred. First, this review is limited by its exclusion of non-English language papers. However, a lack of resources meant that the translation of texts from other languages into English language was not possible. A second concern is publication bias, with studies which report statistically significant results being more likely to be published in scientific journals. However, due to limited resources, only studies identified in electronic online searches were included in the review.

Conclusion

In summary, the identified themes in the literature investigating workload/caseload size, control, professional support, salary, length of time in practice and work setting have been reviewed. However, the impact of many of these risk factors on SLP satisfaction and well-being remains poorly understood. There is a need for more theoretically-driven studies on the topic, and a need for longitudinal data to establish cause and effect relationships between predictor and outcome variables. In addition, limited information on the contribution of individual factors to SLP well-being is available, with only one study taking into account individual differences i.e. Mclaughlin et al. (2010) with the use of the PANAS. Finally, no previous studies have investigated the interaction between different elements of the job, which might boost satisfaction or ameliorate stress in SLPs.

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Appendix B2

Studies reporting job satisfaction, stress or burnout in Speech and Language Therapists (1998-2018)

Reference	Participants Sample size (n) Response rate Country of study Group studied Employment setting	Study design	Area investigated	Measurement method Method/metric used Measures of analysis	Results
Heritage et al. (2018)	n = 293 / Australia SLPs (Members of Speech Pathology Australia) /	Mixed methods: online cross-sectional survey (quantitative and qualitative data)	Embeddedness, intentions to leave (the job and the profession)	Self-report: Role Conflict & Role Ambiguity scales, Satisfaction with Life Scale, Job in General Scale, Global Job Embeddedness Scale Non-parametric correlations, ordinary least squares regression, bootstrapping, + directed content analysis	-role conflict & role ambiguity contributed to turnover intention (τ_b=0.22**) JS contributed to turnover intention (τ_b=-0.57***) and occupation attrition intentions (τ_b=-0.34**). -Model testing relationships revealed JS, role conflict, role ambiguity, embeddedness, perceived availability of other jobs all significantly contributed to intention to leave (F [7, 259] = 26.92***, R^2=0.364, f^2=0.572 – large effect size). -Themes from qualitative phase supported quantitative findings: reasons to stay incl perceived unavailability of other jobs, satisfaction; reasons to leave incl workplace climate, workload related stress, feelings of being burnt out, & links/support

Bruschini et al. (2018)	n = 391 (101 SLPs) / Lazio, Italy SLPs, Physiotherapists (PTs), & Occupational Therapists (OTs) Hospitals & private health care clinics	Cross-sectional survey	Burnout	Self-report: Maslach Burnout Inventory (MBI) & Health & Safety Executive Management Standards Indicator Tool Student t-tests, chi-square tests	-14% of total sample at risk of burnout, no sig differences between SLPs, PTs, & OTs. -High risk scores for MBI subscales: Emotional Exhaustion 32% Depersonalisation 13% Personal Accomplishment 9% -Correlations between burnout risk & working hours (t=-2.195*) -Control, (x^2=9.60**) management support (x^2=14.05**), relationships (x^2=5.51*), role (x^2=16.01**) & change (x^2=4.62*) associated with the risk of burnout
Kasbi et al. (2018)	n = 182 73% Iran SLPs Participants at 13th National Iranian Congress of Speech Therapy	Cross-sectional survey	Burnout	Maslach Burnout Inventory (MBI) Frequency counts Chi squared & regression analysis	44% (n=80) had mild burnout, 53.5% (n=97) had moderate burnout, 2.2% (n=4) had severe burnout X^2 analysis: Significant relationships between burnout and caseload size (p=0.02), income (p=0.03) & training opportunities (p=0.05) Caseload size predicted level of burnout (r=0.12*)
Kalkhoff & Collins (2012)	n = 98 19.6% USA SLPs (American Speech-Language Hearing Association members)	Cross-sectional survey	Job satisfaction	Self-report: Job Satisfaction Survey (JSS) Frequency distributions, means. Single sample t-test, post hoc Bonferroni correction technique, Pearson product	-SLPs in both settings generally satisfied. 32% average, 51% high -Higher satisfaction on JSS than normative mean for average American worker (M=147.3 SD 29.5, M=136.5 SD 12.1, t=3.624*) -SLPs in medical settings significantly higher total JS scores

	Schools and medical settings			moment correlation, chi-squared test, linear multiple regression, one-way ANOVA	than those in schools (M=159.82 SD 30.89, M=139.07 SD 25.07, t=3.608*) -medical:10% low, 15% average, 74% high satisfaction -schools: 22% low, 42% average, 36% high: sig difference for each category across settings (x^2=14.2***) -JS NOT predicted by caseload size, age, years-at-position at $p<0.05$ sig level
Cocks and Cruice (2010)	n = 23 / (posted online) United Kingdom Overseas-trained SLPs working in the United Kingdom Mostly NHS (n=13), also universities, charities, schools, etc.	Online cross-sectional survey	Experience & perspectives of overseas-trained SLPs	Self-report: self-designed questionnaire Frequency counts, cross tabulations + identification of themes for open ended questions	-Benefits (compared to home countries): job “lifestyle” e.g. more holidays/clearer career structure; clinical advantages e.g. ability to pursue clinical specialism; CPD, support & supervision -Negatives: 6/22 (27%) satisfied with waiting lists (longer than in home countries); 9/15 (60%) reported large caseloads (larger than in home countries) leading to dissatisfaction; 9/23 (39%) satisfied with status, half satisfied with salary -Cross-tab analysis: ALL dissatisfied participants had larger caseloads than at home.
Hutchins et al. (2010)	n = 75 41% Vermont, USA State school SLPs	Cross-sectional survey	Job satisfaction, workload satisfaction,	Self-report: self-designed questionnaire Descriptive statistics (measures of central	-Generally satisfied, least satisfied with workload (M=2.41 SD 1.1 on 5 point Likert scale)

			caseload size & best practice	tendency), correlation coefficients *r*	-Sig relationships between workload satisfaction and: salary (r=0.33***), liking the caseload (r=0.66***), professional advancement (r=0.28**), working in schools (r=0.38***), administrative support (r=0.46***), caseload size (r= -0.36***), school hours (r=0.31***), schedules (r=0.44***), parental involvement (r=0.36***), others understanding the role (r=0.35***)
McLaughlin, et al. (2010)	n = 620 21% Australia SLPs All: public, private practice, non-government, private sector	Cross-sectional survey	Turnover & intention to leave	Self-report: ASSET (A Shortened Stress Evaluation Tool) – general stress; Allied Health Professionals' Likelihood Of Resignation Scale (self-designed questionnaire based on previous research – profession-specific stress); PANAS (Positive And Negative Affect Scale); questions by Blau on job search behaviours Logistic regression	31% intended to change jobs 13% intended to change professions Predictions: *More likely to leave a job if:* -age <34 years (B=.654*) -low job security (B=.663**) -not feeling that the work of an SLP met professional needs (B=.543*) *More likely to leave the profession if:* -spend >50% on administrative tasks (B=1.742***) -not feeling that the work of an SLP met professional needs (B=1.300**) -high negative affect (B=.081*) -no children <18 (B=.967*) -hours of work & caseload (type of client) NOT predictors

Harris et al. (2009)	n = 97 42.4% Utah, USA State school SLPs	Cross-sectional survey	Job stress	Self-report: Speech-Language Pathologist Stress Inventory (SLPSI) Single-sample t-test, correlation coefficients *r*, step-wise multiple regression	-Sample mean sig below national mean (Fimian et al, 1991). M=2.4 SD 0.5, M=2.7 SD 0.6, t=-6.0***) -No difference between rural and urban settings All 6 subscales account for total stress score (R^2=0.987, F = 1078***). Lack of professional support strongest
Loan-Clarke et al. (2009)	n = 516 43% United Kingdom Practising (NHS) & non-practising SLPs	Cross-sectional survey: qualitative data (paper part of a larger study using mixed methods design)	Reasons to stay, leave, and return to the NHS	Self-report: self-designed questionnaire Content analysis to code open-response questions – transformed to quantitative data & descriptive statistics produced – frequency analysis	-Reasons to stay: job security (24.2%), pension, CPD, JS/enjoyable/ interesting work (13%) -Reasons to leave: incl excessive workload/pressure/ stress (20.2%), childcare issues, lack of patient contact time, unable to give good patient care, pay -Reasons to return: flexible hours (11%), external rewards (e.g. location, pension, easy travel, work availability) -Negative general perceptions of NHS employment: excessive workload/stress/ pressure most commented on (22.5%)
McLaughlin et al. (2008)	n = 18 30% Australia SLPs Public & private sector	Qualitative: semi-structured interviews	Views on attrition	Semi-structured interviews Identification of themes	-8 themes identified: positive aspects of the career (e.g. working with and helping clients, interesting nature of the work), workload as a stressor, non-work obligations (reason to *stay* in job), effectiveness (decreased personal

					accomplishment), recognition (lack of understanding of the role), support (mediating stress), learning (difficulty accessing CPD) and lack of autonomy (clinical and administrative) -dominant theme: enjoyment and rewards of being an SLP -main source of stress: workload, perceived compromise in quality and quantity of care
Warden et al. (2008)	n = 7 / Western Cape, South Africa SLPs State hospital clinicians	Qualitative: in-depth interviews	Lived experience of SLPs in the public health service	In-depth interviews Phenomenological analysis	-5 themes identified -work setting (teaching hospital) contributes to JS -SLPs struggle to gain control -multidisciplinary team and administrative colleagues are sources of support
Edgar and Rosa-Lugo (2007)	n = 382 64.5% Florida, USA SLPs State school clinicians	Cross-sectional survey	Recruitment & retention of SLPs	Self-report: self-designed questionnaire Frequency distributions, percentages, cross-tabulations, ANOVAs; effect sizes: eta-squared	Satisfaction: top 5 positives all significantly related to retention: -working with children – 74% ($F[4,382]=3.91^*$, $\eta^2=0.044$), -school schedule – 53.7% ($F[4,382]=4.46^*$, $\eta^2=0.050$), -school hours – 44.5% ($F[4, 382]=5.99^{***}$, $\eta^2=0.066$), -school assignment – 40.6% ($F[4,382]=2.86^*$, $\eta^2=0.033$), -availability of experienced mentor – 40.8% ($F[4, 382]=3.13^*$, $\eta^2=0.036$) Top 4 negatives: workload (44.2%), misunderstanding the role

					of the SLP (41.1%), salary (40.1%), caseload (34.6%) -2 of these associated with longevity: workload ($F[4, 382]=2.67^*$, $\eta^2=0.030$) & salary ($F[4, 382]=3.99^*$, $\eta^2=0.045$) -workload associated with retention ($F[4, 382]=3.00^*$, $\eta^2=0.034$) (longevity: how long worked, retention: how long plan to continue)
Smith-Randolph and Johnson (2005)	n = 328 22% USA Physiotherapists, Occupational therapists, SLPs	Cross-sectional survey	Extrinsic & intrinsic job satisfaction, effect on recruitment and retention	Self-report: self-designed questionnaire Frequency distribution, linear regression analysis	-Overall (all Allied Health Professionals): 81% satisfied with career -Predictors of satisfaction (SLP specific): accomplishing career objectives (r=0.397**), realistic workload (r=0.254*), adequate support staff (r=0.263*), balance between work and home (r=0.389**), flexible schedule (r=0.359**), helping people overcome disabilities (r=0.190*) -Predictors of staying in post (SLP specific): accomplishing career objectives (r=0.380**), proper training (r=0.321**), flexible schedule (r=0.428**), role conflict (r= -0.242*), realistic workload (r=0.234*)

Blood, et al. (2002a)	n = 712 71.2% USA SLPs Based in healthcare	Cross-sectional survey	Occupational stress, relationship between occupational stress & life satisfaction	Self-report: Health Professions Stress Inventory (HPSI), Satisfaction with Life Scale (SWLS) Frequency distributions, correlation coefficients *r*	HPSI M=48.5 SD 12.8: low stress SWLS M=23.9 SD 6.1 -sig –ve relationship between job stress & life satisfaction (r= -0.75**) -sig –ve relationship between occupational stress & number of years in profession and job (r= -0.54**, r=0.49** respectively) -no sig relationship between caseload size & stress -"Moderate stress" around salary, workload, conflict between job & family responsibilities, not enough staff, not recognised as "true health professional". -highest stress: workload, staffing, salary
Blood, et al. (2002b)	1207 60.4% USA SLPs Rural, suburban and urban schools	Cross-sectional survey	Job satisfaction	Self-report: Job Satisfaction Survey (JSS), practice-related questions Frequency distributions, hierarchical regression analysis	-JSS M=26.8 SD 14.2: <1SD from normative mean -42.4% generally satisfied -34.1% highly satisfied -significant +ve correlations between JS & years in current position (r=0.59*), JS & age (r=0.52*) -significant –ve correlation between JS & caseload size (r= -0.57*) -Predictors: following accounted for variance - number of years in current position (14%, F=39.3**), caseload size (12%, F=35.6**), age (10%, F=22.4**) -No differences between rural, suburban and urban

Blood, et al. (2002c)	n = 655 65.5% USA SLPs Rural, suburban and urban schools	Cross-sectional survey	Job stress, social support, frequency of interaction	Self-report: Speech-Language Pathologist Stress Inventory (SLPSI), Functional Social Support Scale (FSSS [Social Interaction Scale & Subjective Social Support Scale from Duke Social Support Index]) Frequency distributions, step-wise regression analysis, one way ANOVAs	-overall job stress: 82% "barely noticeable". No sig group differences between rural/suburban/urban -social support: 71% overall satisfaction -low functional social support & little interaction with peers & supervisors predicted high levels of stress (t[651]=32.1***, t[651]=6.35*** respectively) -correlation between SLPSI & FSSS high (r=-0.78**), between SLPSI & frequency of interaction high (r = -0.44**) -various "chronic" stressors: paperwork, overwork, lack of time, large caseloads
Kaegi et al. (2002)	n = 56 44% Canada SLPs (urban Ontario, urban Alberta, rural Alberta areas) Schools	Cross-sectional survey	Job satisfaction & burnout	Self-report: self-designed questionnaire ANOVA, post hoc: least squares difference tests with Bonferroni correction, correlation coefficients *r* + content analysis	-satisfied: rural Alberta – 66%, urban Alberta – 72%, Ontario – 12% -satisfaction & caseload negatively associated (r = -0.313*) -satisfaction & length of years working negatively associated (r= -0.294*) -burnout: rural Alberta – 52%, urban Alberta – 44%, Ontario – 56% -"authority to do the job": majority of Alberta SLPs, half in Ontario -helpful supervisors: over half of Alberta SLPs, 1/3 of Ontario SLPs

	-no significant difference between rural & urban for JS

Key:
/ = not reported
CPD = continuing professional development
HPSI = Health Professions Stress Inventory
JS = job satisfaction
JSS = Job Satisfaction Survey
MBI = Maslach Burnout Inventory
NHS = National Health Service
OT = Occupational therapist
PT = Physiotherapist
SLP = Speech-language pathologist
SLPSI = Speech Pathologist Stress Inventory
SWLS = Satisfaction with Life Scale
USA = United States of America
*p<0.05
**p<0.01
***p<0.0

Appendix C1

Faculty of Business, Law and Social Sciences Research Office

Faculty of Business, Law and Social Sciences
Birmingham City University
4 Cardigan Street
Birmingham
B4 7BD

BLSSethics@bcu.ac.uk

23rd January 2018

Dear Claire Ewen,

Re: 181.17 - The Occupational Psychosocial Wellbeing of Speech and Language Therapists in the United Kingdom

Thank you for your application and documentation regarding the above activity. I am pleased to take Chair's Action and approve the activity which means you may begin.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an Amendment application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead.

Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact BLSSethics@bcu.ac.uk

I wish you every success with your activity.

Yours Sincerely,

Kyle Brown
On behalf of the Faculty Academic Ethics Committee
Business, Law and Social Sciences

Appendix C2

Faculty of Business, Law & Social Sciences Research Office
Birmingham City University
Curzon Building
4 Cardigan Street
Birmingham
B4 7BD

BLSSethics@bcu.ac.uk

Wednesday 28th March

Re: Ewen: 181.17a "The Occupational Psychosocial Wellbeing of Speech and Language Therapists in the United Kingdom"

Dear Claire,

Thank you for your application for approval of amendments regarding the above study. I am happy to take Chair's Action and approve the amendments which means you may continue your research.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an Amendment application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead.

Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact BLSSethics@bcu.ac.uk

I wish you every success with your activity.

Yours Sincerely,

Kyle Brown

On behalf of the Faculty Academic Ethics Committee
Business, Law & Social Sciences

Appendix C3

Faculty of Business, Law & Social Sciences Research Office
Birmingham City University
Curzon Building
4 Cardigan Street
Birmingham
B4 7BD
BLSSethics@bcu.ac.uk

30th August 2018

Claire Ewen
Claire.Ewen@mail.bcu.ac.uk
CC: Craig Jackson Craig.Jackson@bcu.ac.uk

Dear Claire,

Re: Ewen #181.17b - The Occupational Psychosocial Wellbeing of Speech and Language Therapists in the United Kingdom

Thank you for your application for approval of amendments regarding the above study. I am happy to take Chair's Action and approve the amendments which means you may continue your research.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an Amendment application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead. Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity. If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact BLSSethics@bcu.ac.uk

I wish you every success with your activity.

Yours Sincerely,

Kyle Brown

On behalf of the Faculty Academic Ethics Committee
Business, Law & Social Sciences

Appendix C4

Faculty of Business, Law & Social Sciences Research Office
Birmingham City University
Curzon Building
4 Cardigan Street
Birmingham
B4 7BD
BLSSethics@bcu.ac.uk

17th January 2019

Claire Ewen
Claire.Ewen@mail.bcu.ac.uk
CC: Craig Jackson Craig.Jackson@bcu.ac.uk

Dear Claire,

Re: Ewen #181.17c - The Occupational Psychosocial Wellbeing of Speech and Language Therapists in the United Kingdom

Thank you for your application for approval of amendments regarding the above study. I am happy to take Chair's Action and approve the amendments with the following proviso:

The transparency template from the HELS SOPS is included. These are available on moodle.

Given the above you may continue your research.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an Amendment application for approval of the proposed changes. Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead. Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact BLSSethics@bcu.ac.uk

I wish you every success with your activity.

Yours Sincerely,

Kyle Brown

On behalf of the Faculty Academic Ethics Committee
Business, Law & Social Sciences

Appendix C5

Faculty of Business, Law & Social Sciences Research Office
Birmingham City University
Curzon Building
4 Cardigan Street
Birmingham
B4 7BD
BLSSethics@bcu.ac.uk

12th February 2019

Claire Ewen Claire.Ewen@mail.bcu.ac.uk
CC: Craig Jackson Craig.Jackson@bcu.ac.uk
Helen Jenkins Helen.Jenkins@bcu.ac.uk

Dear Claire,

Re: Ewen #181.17d - The Occupational Psychosocial Wellbeing of Speech and Language Therapists in the United Kingdom

Thank you for your application for approval of amendments regarding the above study. I am happy to take Chair's Action and approve the amendments which means you may continue your research.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an Amendment application for approval of the proposed changes. Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead. Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact BLSSethics@bcu.ac.uk

I wish you every success with your activity.

Yours Sincerely,

Kyle Brown
On behalf of the Faculty Academic Ethics Committee
Business, Law & Social Sciences

Appendix C6

SPEECH AND LANGUAGE THERAPY OCCUPATIONAL WELL-BEING SURVEY

INFORMATION SHEET (PHASE 1)
PART 1

You are being invited to take part in a research study about the profession within which you work. The following information tells you why the study is being done and what it will involve. Please read through this carefully and take your time before deciding whether or not you wish to be involved.

What is the purpose of this research?

Speech and language therapists (SLTs) are committed to evidence-based practice. While much research is conducted to establish the efficacy of treatments and to investigate the well-being of our clients, very little academic research has been carried out with British SLTs themselves. This makes SLTs in the NHS, in education and the third sector, and in independent settings; a unique, under-researched working population.

I am investigating whether the role of a Speech and Language Therapist working clinically – in ANY sector across the UK – is associated with varying levels of workplace well-being and health issues – both positive and negative.

What does taking part involve?

If you agree to take part in the project, you will need to complete a consent form. There are two phases to this project. ***You do not have to take part in both phases, but will be given the opportunity to do so, if you wish***:

Phase 1. (Apr-May2018) You will complete a survey (the anonymous online questionnaire that follows this information) that will measure demographics, work history and present status, and feelings about work. You will also be asked, at the end of the questionnaire, if you would be willing to complete a follow up questionnaire at a future date and/or take part in an interview (Phase 2). Participants who agree to complete the follow up questionnaire will be contacted again in July 2018, via email.

Phase 2. (Oct2018-Jan2019) Participants willing to take part in one-to-one interviews will be invited to attend an interview at their convenience, at a location suitable to them.

Completing this online questionnaire does not mean you have volunteer to complete the follow up questionnaire, or to participate in an interview.

How long will the study last?

Phase 1 of the research, completion of this online questionnaire, can be done remotely without the researcher being present. Once you have provided consent, the completion of the questionnaire should take around 20 minutes for most people.

The follow-up questionnaire, which will be circulated to participants at a later date, and which is optional, will be shorter.

Phase 2 of the research (which you are not obliged to take part in) will involve voluntary interviews. Each interview will last about 45 minutes.

What are the possible benefits of taking part?

This research will advance understanding of the factors that contribute to (dis)satisfaction with the work that SLTs do. It is hoped that this will enable SLTs to reflect upon and adjust responses to stress, thus enabling clinicians to adapt effectively to their jobs and to enhance their psychological

health at work. Participants may benefit from taking part as the findings of the research could be used to empower them to initiate more open dialogue between themselves and their employers, thus improving retention of the workforce through the adaptation of workplaces to people. Finally, managers could use the research to instigate changes to the workplace, which would benefit participants.

Are there any disadvantages of taking part?

It is not anticipated that you will experience any disadvantages if taking part. There is a possibility that the project might lead to you identifying some negative feelings around work, which could lead to distress on your part. Should you need support to cope with identified stress, you are advised to contact your GP.

Expenses and payment

It is not anticipated that you would incur any expense. There is no payment for participating. Should you wish, you will be entered into a draw and £200 will be given to a charity selected by the winner.

What happens at the end of the research project?

The results of the study will be written up in my PhD thesis and published in Speech and Language Therapy and other health and well-being journals. The results of the research will be published in the RCSLT Bulletin, so that these are available to you. The Royal College of Speech and Language Therapists has agreed to support the dissemination and application of the research findings through their practice networks, website and publications, as appropriate, to ensure that potential benefits of the research for the profession is fully realised.

Will my taking part in the study be kept confidential?

Yes. You will not be identified by name or in any other way in any results or publications. Consent forms will be separated from questionnaires and you will not be required to add your name to questionnaires – information you provide will therefore be anonymous. The names of those participants who agree to be interviewed will be kept confidential, and will only be known by me, as the researcher.

What if I change your mind?

You have the right to withdraw at any time before the data is analysed. Participation is completely voluntary and your own decision. You also have the right to have any data that you have supplied destroyed on request, up until the point where the data is analysed (Aug 2018 for the questionnaire, and Feb 2019 for the interviews).

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

☐ No, I am not interested

☐ Yes, I am interested

SPEECH AND LANGUAGE THERAPY OCCUPATIONAL WELL-BEING SURVEY

INFORMATION SHEET (PHASE 1)
PART 2

What if there is a problem?
If you have a concern about any aspect of this project, please feel free to contact Claire Ewen (Claire.Ewen@mail.bcu.ac.uk) and she will do her best to answer your questions. If this does not resolve any concern, you can contact Professor Craig Jackson (Craig.Jackson@bcu.ac.uk) who is the supervisor for this project. If you wish to contact the Research Ethics Committee who approved this study, you may do this through the the Business, Law and Social Sciences Faculty Research Ethics Committee at Birmingham City University (blssethics@bcu.ac.uk).

Who is organising and funding the research?
The project is being sponsored and funded by Birmingham City University.

Who has reviewed the study?
This study was given ethical approval for conduct by the BCU Faculty of Business, Law and Social Sciences Research Ethics Committee.

Who should I contact for more information?
Please contact Claire Ewen if you have any questions or would like more information – Claire.Ewen@mail.bcu.ac.uk – She will be happy to answer any further questions you may have.

What should I do if I would like to take part?
Please read this information and the consent form carefully.

Should you wish to participate you may then complete your consent form. This will indicate that you have provided consent to participate in the study.

Thank you very much for taking the time to read this information.

☐ I have read and understood the information above

SPEECH AND LANGUAGE THERAPY OCCUPATIONAL WELL-BEING SURVEY

Participant Consent Form (Phase 1)

Title of the project: The occupational psychosocial well-being of speech and language therapists in the United Kingdom

Name of Researcher: Claire Ewen

Please read the statements below and tick the necessary box if you wish to participate in the study.

"I confirm that I have read and understood the participant information sheet for this study and have been provided with the opportunity to ask questions which have been answered satisfactorily."

"I understand that my participation is voluntary and that I am free to withdraw at any time before the data is analysed, without giving any reason, and without my rights or employment being affected."

"I agree to take part in the above study."

"I agree for the researchers to use any data that I have provided in the writing up of the PhD thesis and in the publication of related journal articles."

☐ Yes, I consent

SPEECH AND LANGUAGE THERAPY OCCUPATIONAL WELL-BEING SURVEY

THIS QUESTIONNAIRE SHOULD TAKE AROUND 20 MINUTES TO COMPLETE.

It will be easier to complete this survey on desktop or laptop than on a mobile phone. If you do wish to use your mobile phone, you need to rotate it to a landscape view.

Please answer questions with your immediate thoughts and don't spend too long pondering over them. Your first answer is usually the 'right' one.

First, it would help the researcher if you tell us a little about yourself. The information that you provide will enable the researcher to demonstrate that as broad a sample of speech and language therapists as possible, have participated.

When given options, please circle your choice.

Demographic Questions (5 questions)

1. What is your date of birth? *Please enter as dd/mm/yyyy*

____

2. Please state your gender.

- *Female*
- *Male*
- *Identify as other*

3. What is your current relationship status?

- *Single*
- *Living with partner*
- *I have a partner but I am not living with them*
- *Married*
- *Separated*
- *Divorced*
- *Widowed*
- *Other (please specify)________________________*

4. How many children under 16 do you currently look after at home? *Please enter a number (not a word)*

____

5. What is your ethnic group?

- *White British/English/Welsh/Scottish/Northern Irish*
- *White Irish*
- *White Gypsy or Irish Traveller*
- *Any other white background, please describe*

- *Mixed: White and Black Caribbean*
- *Mixed: White and Black African*
- *Mixed: White and Asian*

- *Any other Mixed/Multiple ethnic background, please describe*

- *Asian/Asian British: Indian*
- *Asian/Asian British: Pakistani*
- *Asian/Asian British: Bangladeshi*
- *Asian/Asian British: Chinese*
- *Any other Asian background, please describe*

- *Black/Black British: African*
- *Black/Black British: Caribbean*
- *Any other Black/African/Caribbean background, please describe*

- *Other ethnic group: Arab*
- *Any other ethnic group, please describe*

Background questions (9-12 questions)

In the next section, please tell us about your work.

6. What was your route in to SLT? (please circle)

- *UK undergraduate Degree*
- *UK Postgraduate 2-year Degree (Masters)*
- *Overseas Degree (recognised by the HCPC)*

7. What is your highest educational attainment?

PHD	*MEd*
Professional Doctorate	*MPhil*
DEd	*MA*
MBA	*Other Masters degree*
MSC	*Undergrad Degree*

Other (please state) ________________________________

8. Did you have previous work experience before becoming an SLT? (please include paid employment that you did while studying)

Yes *No*

9. If 'yes', was your experience in any of the following (please circle as many options as apply):

Teaching	*Occupational Therapy*
Nursing	*Business*
Physiotherapy	*SLT Assistant*

Paid employment while a student. Please say what it was: ______________________
Other (please say what you did): ________________________

10. When did you qualify as an SLT? Please give the year

____

11. Which part of the country do you currently work in?

England *Northern Ireland* *Scotland* *Wales*

12. Do you currently work (please circle as many options as apply):

Full Time (approx. 38hrs per week) *Part Time* *Flexible Working* Hours

13. Who is the main income provider in your household?

- *Me*
- *My partner*
- *My partner and I are equal providers*
- *I am the sole income provider*

14. What is your work setting (please circle as many options as apply):

State Hospital(s)
Community Clinic(s)
Residential Setting(s)
Nursery(ies)
State Mainstream Primary School(s)
State Primary Special School(s)
State Mainstream Secondary School(s)
State Secondary Special School(s)
Higher Education Institution
Private Primary Schools(s)
Private Secondary School(s)
Private Clinic(s)
Private Hospitals(s)
Domiciliary
Other (please say where) ____________

15. Are you currently (please circle all that apply)

Working clinically
Working for a university/other educational establishment
Working in research
Not working
Retired
Doing something else (please say what you are doing) _________________

16. If you are no longer work clinically, how long ago did your last clinical job end?

Less than 12 months ago
Between 1 year and 5 years ago
Over 5 years ago

17. Why did you leave your last clinical job? Please give as much detail as you wish (*This question is mandatory, if 'working clinically was not checked in question 15. It is a branching question that then allows participants to ONLY answer the GJSS & GHQ-28, without answering clinically specific questions)*

____-

Nature of employment (3-5 questions)

18. Are you currently self-employed?

Please note that for this survey, 'self-employed' means that you are responsible for the financial management of your own business. This category therefore includes working as an independent SLT who contracts directly with parents/carers.

It also includes subcontracting to one or more employers (e.g. a school/charity/private practice) but invoicing them (rather than being on their payroll). In this scenario, you might well work for multiple employers. This would still constitute ONE job i.e. your position as an independent therapist.

Your self-employment may be a combination of contracting directly with clients and working for different companies.

- *Yes, for all of my working week*
- *Yes, for part of my working week*
- *No*

19. Please tell us more about being self-employed. Feel free to add information should you with to. Are you:

- *Working as a sole practitioner, contracting your services to various clients/employers*
- *The owner/partner of an independent practice with more than one SLT*

20. Are you currently employed by (please select as many options as apply)

The NHS	*A school*
A 3rd sector employer (e.g. a charity)	*A higher education institution*
A private company	*An education service*
An independent practice	
Other. Please say what you are doing __________________	

21. If you have more than two jobs, you will only be asked to comment on the TWO that constitute the substantial part of your week.

Please let us know if you have THREE or more jobs e.g. two days working for the NHS, two days a day as an independent therapist contracting do different organisations, and a day a week at a university.

Yes *No*

22. Following on from the previous questions, can we ask you to please confirm your working arrangements by selecting the option that best matches your situation. Because this survey is looking at clinical jobs, we need to you to differentiate between jobs that are clinical and those that are not (e.g. working in higher education):

- *I am employed by ONE service/council/authority/company/practice/etc and my work includes clinical responsibilities.*
- *I work part of the week for myself, as an independent therapist working clinically AND am employed for part of the week in a clinical capacity e.g. by the NHS*
- *I am employed by TWO (or more) different services/authorities/companies/practices/etc. BOTH (ALL) OF THESE POSITIONS INCLUDE CLINICAL RESPONSIBILITIES e.g. NHS & a school directly*
- *I work part of the week for myself, as an independent therapist working clinically AND am employed for part of the week, but NOT in a clinical capacity e.g. by a university*
- *I am employed by TWO (or more) different services/authorities/companies/practices/etc. ONLY ONE OF THESE INCLUDES CLINICAL RESPONSIBILITIES e.g. NHS & a university*

If the respondent has indicated in Question 5 that they have more than one clinical job, they then see the following information:
You have indicated that you have more than one clinical job. In the following sections, you will be able to comment on each job separately. This will provide the researcher with the information needed to compare and contrast different types of employment.

Remember that if you have more than two jobs, you will be commenting on the TWO that constitute the substantial part of your week.

....

Job characteristics (32-37 questions, depending on skip logic)

In the next section, please tell us about your work.

23. How long have you been in your current role?

    ______years ________months

24. Is your contract (please circle as many as apply):

    Permanent *Temporary* *Fixed Term*
    Maternity Cover *Locum cover*

25. How many hours per week are you paid to work? ____________________________

26. How many additional (unpaid) hours per week do you do on average? __________

27. What is the size of your caseload? Please provide a number __________________

28. How many different sites do you regularly work in over a week? Please provide a number _______

29. Are you the only SLT in your current setting(s)?

    Yes *No*

30. Do you work with a speech and language therapy assistant(s)?

    Yes *No*

31. Please state the number of speech and language therapists with whom you work _____________

32. Do you feel that you are able to use the skills and knowledge you learned at university in your job?

    hardly ever *some of the time* *most of the time* *always*

33. Do you have a designated, appropriate space in which to work?

    Yes *No*

34. If 'no', where do you often find yourself working? Please circle as many as apply.

    A corridor *The corner of an office*
    My car *Other (please say where)* ________________

35. Approximately how many days over one week, do you need to work in a makeshift space at some point? __________________

36. Does your job usually involve any other physical demands (please click on any that apply):

    Prolonged sitting
    Prolonged work on a computer/tablet/keyboard
    Prolonged use of the telephone
    Using uncomfortable/inappropriate furniture
    Long periods of driving
    Other (please state) ______________________
    Sitting in very small chairs
    Crouching
    Sitting in awkward postures
    Bending
    No other physical demands

37. Does your job involve regular/routine manual handling of any kind (e.g. carrying bag of files or therapy equipment/assisting clients to move)?

Yes *No*

38. If 'yes', how many days in a typical week are you required to use manual handling skills? __________

39. Have you had manual handling training?

Yes *No*

40. When at your workstation (desk/table where you might do paperwork), Is your seating suitable (e.g. a chair at comfortable height with back support)?

Yes *No*

41. Have you had a display screen equipment (DSE) assessment for your current work station?

Yes *No*

42. During a typical working day, how many minutes would you spend on:

*Phone*_____ *tablet* _____ *laptop* _____ *desktop* ______

43. Do you access emails on a (please circle as many as apply):

phone *tablet* *laptop* *desktop*

44. Do you read and send work emails outside of your working hours?

yes *no*

45. Do you respond to work emails throughout the day?

yes *no*

46. In normal circumstances, is your job cognitively demanding (e.g. having to problem solve, justify decisions, prioritise competing demands)?

Low demand 1 2 3 4 5 6 7 8 9 10 High demand

47. How much support do you feel you get at work (e.g. formal supervision, informal help e.g. with clinical queries, to solve problems or to reflect on interactions)?

Inadequate support 1 2 3 4 5 6 7 8 9 10 Just the right amount of support

48. If you need support at work, is there someone you can access easily on the day that you need it?

yes *no*

49. How often are you able to talk to your colleagues/fellow professionals (other speech and language therapists)?

Every day *At least once a week* *At least once a month* *Less than once a month*

50. Do colleagues (SLTs or other professionals) come to you for support at work?

yes *no*

51. Is your job worthwhile?

yes *no*

52. In usual circumstances, is your job emotionally demanding (e.g. having to support clients/families/carers who may be vulnerable/distressed/angry/grieving or having to support staff who are struggling)?

Low demand 1 2 3 4 5 6 7 8 9 10 High demand

53. How much emotional support do you receive at work (e.g. you are listened to and understood, your feelings are respected, you can talk through the impact that clinical or other professional interactions might have had on you)?

Inadequate support 1 2 3 4 5 6 7 8 9 10 Just the right amount of support

54. In the last 6 months have you taken sick leave?

yes *no*

55. In the last 6 months have you still gone to work when you've felt ill?

yes *no*

56. Do you see taking sick leave as a last resort?

yes *no*

57. Have you ever taken a mental health self-care day?

yes *no*

58. If yes, were you honest about taking a mental health self-care day?

yes *no*

59. In usual circumstances, how much control do you have in doing your job? (e.g. able to work flexible hours, deciding which tasks to prioritise and when to do them, selecting a therapy approach best suited to your patient/client, influencing service delivery)

Low control 1 2 3 4 5 6 7 8 9 10 High control

60. **It would really help the researcher if you could just answer one more question about the characteristics of this job. Please open your diary to a typical week and list the five things that you spend most of your time on at work. Include anything that you do as part of your job. Some examples of these (listed alphabetically) are:**

Administrative tasks/paperwork (including aim writing/report writing)
Continuing professional development
Email
Face-to-face client work
Meetings/liaison
Therapy related activities e.g. planning sessions/creating resources
Training others
Travel

Please feel free to include tasks that don't appear on this list.

Activity	Approximate percentage of time spent (these may total 100, but they may not – as you're only listing the top 5 things that take up your time
1	
2	
3	
4	
5	

………..

Dispositional traits & feelings about life (9 questions)

The next set of short questions are related to your feelings about yourself, generally. Please try to be as honest and accurate as possible.

61. Thinking about myself and how I normally feel, in general, I mostly experience positive feelings (For example: I feel alert, inspired, determined, attentive)

    Disagree strongly 1 2 3 4 5 6 7 8 9 10 Agree strongly

62. Thinking about myself and how I normally feel, in general, I mostly experience negative feelings (For example: I feel upset, hostile, ashamed, nervous)

    Disagree strongly 1 2 3 4 5 6 7 8 9 10 Agree strongly

63. In general, I feel optimistic about the future (For example: I usually expect the best, I expect more good things to happen to me than bad, it's easy for me to relax)

    Disagree strongly 1 2 3 4 5 6 7 8 9 10 Agree strongly

64. Overall, I feel that I have positive self-esteem (For example: On the whole I am satisfied with myself, I am able to do things as well as most other people, I feel that I am a person of worth)

    Disagree strongly 1 2 3 4 5 6 7 8 9 10 Agree strongly

65. I am confident in my ability to solve problems that I might face in life (For example: I can usually handle whatever comes my way, If I try hard enough I can overcome difficult problems, I can stick to my aims and accomplish my goals)

    Disagree strongly 1 2 3 4 5 6 7 8 9 10 Agree strongly

66. How much control do you feel that you have over your life in general?

    No control 1 2 3 4 5 6 7 8 9 10 Complete control

67. Overall, I feel that I am satisfied with my life (For example: In most ways my life is close to my ideal, so far I have got the important things I want in life)

    Disagree strongly 1 2 3 4 5 6 7 8 9 10 Agree strongly

68. On a scale of one to ten, how depressed would you say you are in general? (e.g. feeling 'down', no longer looking forward to things or enjoying things that you used to).

    Not at all depressed 1 2 3 4 5 6 7 8 9 10 Extremely depressed

69. On a scale of one to ten, how anxious would you say you are in general? (e.g. feeling tense or 'wound up', unable to relax, feelings of worry or panic)

Not at all anxious 1 2 3 4 5 6 7 8 9 10 Extremely anxious

………..

OUTCOMES: PUBLISHED SCALES

A. The Speech-Language Pathologist Stress Inventory (SLPSI). Only respondents who have clinical jobs answer this set of questions.

This section includes your feelings about areas that are specific to speech and language therapy. Please tick the box that most reflects how you feel.

Items in italics are the outcomes, all respondents only do these once. Non-italicized items are the predictors (i.e. ask about clinical job characteristics). Respondents with TWO clinical jobs do these twice.

		Never	Seldom	Sometimes	Often	Always
1	I have little time to prepare adequately for sessions					
2	I have little time for personal work targets					
3	I have too much work to do					
4	My caseload is too big					
5	I lack opportunities for promotion or advancement					
6	*I lack recognition from other professionals*					
7	I receive an inadequate salary					
8	I lack control over service delivery models					
9	I lack emotional and intellectual stimulation					
10	I lack continuing professional development opportunities					
11	I have no time to get tasks done					
12	I am easily overcommitted					
13	I have no time to relax					
14	*I think about other things while at work*					

15	I feel administrative policies limit my effectiveness					
16	I feel administrative policies limit my professional growth					
17	I feel my needs are unmet at work					
18	*I feel my professional life is not contributing to my personal life*					
19	I work with too many clients/patients who have complex needs					
20	*I feel insecure about my job*					
21	*I feel unable to cope*					
22	*I feel depressed*					
23	*I feel anxious about work*					
24	*I call in sick when I am not unwell*					
25	*I use prescription or over-the-counter drugs*					
26	*I get angry*					
27	*I experience rapid and shallow breathing*					
28	*I use alcohol to wind down.*					
29	*I experience heart pounding or racing*					
30	*I experience stomach pain*					
31	*I feel fatigued*					
32	*I sleep more than usual*					
33	*I procrastinate*					
34	I feel my clients/patients or their carers are poorly motivated					
35	I am required to manage behaviour problems					
36	I feel my clients /patients make little progress					
37	I have too much paperwork					
38	I experience inflexible scheduling					

39	I lack adequate training for my job requirements					
40	I lack sufficient resources					
41	I lack support					
42	I lack opportunities to consult with other professionals					
43	I feel my clients/patients are not improving					
44	*I feel other (non-SLT) professionals do not understand the work that I do*					
45	I don't feel like a member of the team in the setting where I work					
46	I lack adequate space in which to work					
47	I experience poor professional interactions					
48	*I feel the public doesn't value the work that I do*					

B. The Generic Job Satisfaction Scale (GJSS). All respondents answer this set of questions.

The next section includes statements about your job satisfaction generally. Please tick the box that reflects how you feel.

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree	Not applicable
I receive recognition for a job well done						
I feel close to the people at work						
I feel good about working at this company						
I feel secure about my job						
I believe management is concerned about me						
On the whole, I believe work is good for my physical health						
My wages are good						
All my talents and skills are used at work						
I get along with my supervisors						
I feel good about my job						

70. All things considered, I feel that I am happy with this job.

Disagree strongly 1 2 3 4 5 6 7 8 9 10 Agree strongly

C. The General Health Questionnaire – 28 (GHQ-28). All respondents answer this set of questions.

Finally, we would like to know if you have had any medical complaints and how your health has been in general over the last few weeks. Please answer ALL the questions by ticking the answer which best applies to you. Remember that we want to know about PRESENT and RECENT complaints, not those that you have had in the past. It is important to answer ALL questions.

Have you recently				
been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual

Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
Been satisfied with the way you've carried out your tasks?	More satisfied	About the same as usual	Less satisfied than usual	Much less satisfied
Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely has
Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

………

Final questions

71. Having completed this questionnaire, please would you indicate roughly what your total earnings are? We feel that this is important information in light of the ever-present changes to how jobs are banded in the NHS, funding cuts to education and the fluctuating private sector. However, we fully understand that you might not want to disclose this information, so providing this information is optional. Please remember that any information provided will be anonymised and kept confidential.

- *Less than £20,000 per annum*
- *£20,000 to £29,000 per annum*
- *£30,000 to £39,000 per annum*
- *£40,000 t0 £40,000 per annum*
- *£50,000 or above per annum*
- *Prefer not to say*

72. Finally, is there anything else you would like to say? …………………………………………..

Thank you for taking park in the study. In order to help the researcher further, would you be interested in:

Completing a SHORTER follow-up questionnaire in 3 months' time

Yes ***No***

Being contacted for a follow up interview where you can share your views more fully

Yes ***No***

If you have indicated that you would be interested in either completing a second (shorter) questionnaire, or in being contacted for a follow up interview, please leave your contact details.

All information provided will be kept confidential, however if you do not wish to include your email, please use your mobile number.

Email address: ***Mobile number:***

If you would like to be entered into a raffle, the prize for which will be £200 towards a charity of your choice, please leave your contact details. When all questionnaires are in and data collection has closed one winner will be drawn at random and contacted directly by the researcher. At that point the winner will be able to specify their chosen charity.

……….

Debrief

Thank you again for your participation.

If you are affected by any of the issues raised in the questionnaire, please contact your General Practitioner for advice and support.

If you have any concerns or queries about the research, please contact the researcher (Claire Ewen), the supervisor of the project (Professor Craig Jackson) or the Business, Law and Social Sciences Faculty Research Ethics Committee at Birmingham City University, using the contact details below.

Contact details

Researcher
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Business, Law and Social Sciences Ethics Committee: blssethics@bcu.ac.uk

Appendix C7i

BIRMINGHAM CITY University

PHASE 2 PARTICIPANT INFORMATION SHEET (p1/2)

The occupational psychosocial well-being of speech and language therapists in the United Kingdom

STUDY BACKGROUND

You are being invited to take part in the second phase of the research study on the well-being of speech and language therapists in the UK. The study looks at elements of well-being such as satisfaction, stress and anxiety. We are interested in your experiences of working as an SLT, and how your work is associated with varying levels of wellbeing and health issues – both positive and negative.

Claire Ewen is the lead researcher, and the project is supervised by Professor Craig Jackson, Dr John Galvin, and Dr Helen Jenkins at Birmingham City University, and Dr Jagjeet Jutley-Nielsen at Warwick University.

The project has been approved by the university's Faculty of Business, Law and Social Sciences Research Ethics Committee.

WHAT WILL YOU NEED TO DO?

An interview will be arranged at a time and location of your convenience. You will be asked about:

- Becoming a speech and language therapist
- Your own well-being
- Your job

At the end of the interview you will be given a debriefing sheet, including details about keeping in touch as the study progresses, should you want to.

HOW LONG WILL THE STUDY LAST?

On average, each interview takes about 60 minutes but could take a little less or longer. There is no strict time limit.

ARE THERE ANY RISKS IN TAKING PART?

There are no specific risks to this study over and above those experienced in every-day life. However, the study does ask about experiences at work, as well as work stress and anxiety. If you find this distressing or upsetting, please tell the researcher. You can stop the interview and carry on when you feel able, or stop the interview completely, at any time.

ARE THERE ANY BENEFITS IN TAKING PART?

Although there are not direct benefits from taking part, it is hoped that this research will give a much better idea of the current well-being of SLTs working in the UK. This will hopefully contribute to improving the way that the well-being of SLTs is supported in the workplace. You can also let the researcher know if you would like to be contacted with news about the project. We will be glad to send you updates or answer any questions.

BIRMINGHAM CITY
University

PHASE 2 PARTICIPANT INFORMATION SHEET (p2/2)

YOUR RIGHT TO WITHDRAW AND WITHOLD INFORMATION

In line with the regulations outlined by the British Psychological Society, you can stop being a part of the research study at any time without explanation. You can have your data withdrawn for up to 2 weeks after the interview by contacting the researcher and telling her your unique pseudonym, which will be agreed at the start of the interview. Please see contact details below if you wish to withdraw your data. During the study, you also have the right to refuse to answer or respond to any questions. Please ask at any point in the study if you are unsure about what any of the questions mean.

YOUR RIGHT TO CONFIDENTIALITY/ANONYMITY

Any personal information you give cannot be identified by anyone else other than the researchers and will be stored confidentially, using the unique pseudonym that is agreed at the start of the interview. You will be asked to provide a pseudonym on a participant information sheet which you will be asked to complete and hand back to the researcher at the beginning of the interview. You may also indicate whether you wish to be kept updated about the project. Should you wish to be kept updated, the email address that you have already provided will be used. This will be kept separately from your interview transcript.

Data will be stored in line with the General Data Protection Regulations (GDPR).

A digital Dictaphone provided by Birmingham City University will be used to make an audio recording of the interview. No video equipment will be used. As soon after the interview has been completed as possible, the audio recording will be transferred to a university-provided, password-protected encrypted laptop, and saved to a secure university site which only the researcher and supervisors will be able to access. After this the recording will be deleted from the Dictaphone.

The researcher (Claire Ewen) may also take notes during the interview. These will be stored in a locked cabinet.

WHO IS ORGANISING THE RESEARCH?

The lead researcher is **Claire Ewen** and you should try to contact her in the first instance with any queries. She can be contacted at:
Claire.Ewen@mail.bcu.ac.uk

The supervisors can also be contacted. They are:
Professor Craig Jackson: Craig.jackson@bcu.ac.uk
Dr John Galvin: John.galvin@bcu.ac.uk
Dr Helen Jenkins: Helen.jenkins@bcu.ac.uk

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law & Social Sciences faculty ethics committee directly at blssethics@bcu.ac.uk

Appendix C7ii

BIRMINGHAM CITY University

The occupational psychosocial well-being of speech and language therapists in the United Kingdom

Data protection and your rights

Birmingham City University ('BCU') is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. BCU will use your name, and contact details (email and/or mobile phone number) to contact you about the research study, and make sure that relevant information about the study is recorded to oversee the quality of the study. Individuals from BCU may look at your research records to check the accuracy of the research study. The only people in BCU who will have access to information that identifies you will be people who need to contact you to arrange an interview and/or to disseminate findings in the future, people who audit the data collection process and people who manage data storage and archiving.

BCU will retain evidence of your participation in this study through the signed consent form for up to three years after the project has been completed. Therefore, we anticipate retaining some of your personal data up until January 2023. This is in accordance with the University's legal obligations and the time you have available in which you may wish to raise any issues or concerns with us about your participation in this study. After this period, BCU will securely destroy information held about you.

You can find out more about how we use your information by contacting:

Claire Ewen (project lead)
Claire.ewen@mail.bcu.ac.uk

For more information about how the University can process your personal data for research, please see the University Privacy Statement, available here: https://www.bcu.ac.uk/about-us/corporate-information/policies-and-procedures/privacy-notice-for-research-participants

If you have any concerns about how we use or handle your personal data please contact the University's Data Protection Officer using the following contact details:

By Email to: informationmanagement@bcu.ac.uk

By Telephone on: +44 (0)121 331 5288

By Post to: Data Protection Officer
Information Management Team
Birmingham City University
University House
15 Bartholomew Row
Birmingham
B5 5JU

If you are not content with the how we handle your information we would ask you to contact our Data Protection Officer to help you who will investigate the matter. However, you do also have the right to complain directly to the Information Commissioner at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF. Information about the Information Commissioner is available at: http://ico.org.uk.

Version 1.0_01.10.18.18

Appendix C7iii

Participant Consent Form (Phase 2)

THE OCCUPATIONAL PSYCHOSOCIAL WELL-BEING OF SPEECH AND LANGUAGE THERAPISTS IN THE UK

BRIEF SUMMARY OF PROJECT

This study is looking at the well-being of speech and language therapists in the UK. It investigates elements of well-being such as satisfaction, stress and anxiety. We are interested in your experiences of working as an SLT, and how your work is associated with varying levels of wellbeing and health issues – both positive and negative.
We need to make sure that you understand the nature of the research, as outlined on the Participant Information sheet, so that you can take part in this study. Please initial the boxes to indicate that you understand and agree to the following conditions:

	Initials
I confirm that I have read the information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw for up to 2 weeks after interview without giving any reason, and without my legal rights being affected.	
I understand that my data is anonymous and will be stored on secure university servers (or in secure storage when on paper). I understand that it will only be used by the investigators for research purposes.	
I agree to audio recording and the use of anonymised quotes in research reports and publications.	
I understand that the audio from this interview will be recorded via a digital Dictaphone and that the recording will be processed in accordance with the information sheet.	
I agree for the researchers to use any data that I have provided in the writing up of the PhD thesis, in the publication of related journal articles, and for conference presentations.	
I agree to take part in this study.	

______________________	__________	__________________
Name of Participant	Date	Signature
______________________	__________	__________________
Principal Researcher	Date	Signature

THIS IS A SEPARATE PAGE

Your unique pseudonym: ____

Appendix C8

Participant self-determination

An example of participant self-determination is provided, including involvement in ensuring anonymity, and of ongoing consent, can be taken from the interview with Kathryn. She appears to be conscious of wanting to remain anonymous through the interview. Part-way through she returns to the discussion of anonymity held before commencing the interview (line 194):

Kathryn: Yeah. I don't want to say anything that will identify the organization but… (continues to recount an incident)

Later, about to describe an event that happened at work, she says (line 340):

Kathryn: Yeah. Although I'm not sure, again, it's about identifying myself.

The researcher reassures her that she will be able to withdraw consent for the use of anything that she is not willing to be used:

Claire: Okay. If there's anything that we feel – you know, afterwards – when we end – if you want to say, "Please don't use that", that's fine. And I'm happy to send you stuff, and say, "Does this look okay?" I won't use anything without your permission.

Kathryn: And maybe – you know – just describe it as a very stressful, unusual situation – but… (continues to recount experience)

After the audio recording of the interview had been transcribed, a summary was created, and emailed to Kathryn for participant checking. She replied, stating:

It's good to hear from you, and I bet you're glad to have finished the transcriptions. I've read the attachment and I'm happy for you to use it but would be grateful if you could remove the following section:

[she then includes the section that details an experience that she had related, and which was described in general terms only]

It's just that I still feel quite wary of that whole episode at work and would prefer if it wasn't included. Everything else is OK, though.

Katherine was the only participant who asked for part of the interview not to be used. The reviewer felt that omission of this one specific incident would not detract from a reader's ability to access Kathryn's experience and feelings as Kathryn was happy for the rest of the interview to be used.

Appendix C9

Royal College of
Speech and Language
Therapists
2 White Hard Yard
London
SE1 1NX

Date: 8th June 2017

Dear Claire Ewen

Re: Factors influencing job satisfaction among Speech and Language Therapists within the United Kingdom

The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists in the UK, representing more than 17,000 members. It facilitates and promotes research into the field of speech and language therapy – the care for individuals with communication, swallowing, eating and drinking difficulties. It promotes better education and training of speech and language therapists and is responsible for setting and maintaining high standards in education, clinical practice and ethical conduct.

The proposed project would meet one of our priorities to support the development, synthesis and dissemination of research that has direct relevance and potential benefit to clinical services and service users.

If successful, the RCSLT would be pleased to support the dissemination and application of the research findings through our practice networks, website and publications, as appropriate, to ensure that potential of the research for the profession is fully realised.

Yours sincerely

CEO, RCSLT

Chair, RCSLT

Appendix C10

COLUMN

Claire **Ewen**

Opinion

Claire Ewen argues that the wellbeing of SLTs is paramount to ensure a healthier workforce and better outcomes for service users

How's your occupational health?

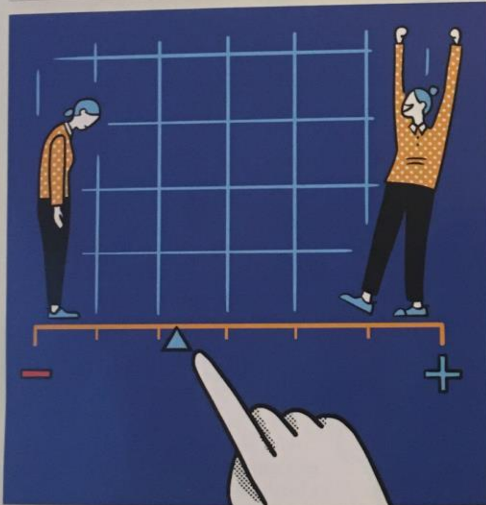

ILLUSTRATION **Sara Gelfgren**

As a paediatric therapist working in a mainstream primary school, I am very proud to be an SLT. Over the 23 years that I have been practising, I have met so many therapists who are passionate about supporting children and adults with speech, language and communication needs; people who strive every day to give voice to their clients and who make every effort to further our profession through their evidence-based work, their research and, above all, their compassion and kindness. Over the past few years I have also met and worked with therapists who love what they do but say that they are increasingly stressed in their roles. Whether working in the public or the private sector, more and more people seem to be struggling with the demands that their jobs place on them.

This really got me thinking. As a 'caring profession', we put all our energies into developing our clinical knowledge – our focus is (quite rightly) on our clients. We do our best to look after them, but do we look after ourselves? We need to look after our wellbeing in order to maximise our impact. I decided to have a closer look at 'what works' for us. What do we love about our jobs and want more of? Which bits frustrate us and how can these be eliminated or at least changed? So I registered for a PhD in Occupational Psychology at Birmingham City University (BCU) and set about trying to find out.

> *"There is a real paucity of research into the wellbeing of SLTs in the UK"*

Now my weeks are divided between the regular work of a mainstream primary school therapist and reading as much as I can find about SLTs. The first thing I discovered was that there is a real paucity of research into the wellbeing of SLTs in the UK. In the past 30 years there are only a few studies that have investigated our satisfaction and our stress. Studies in the USA and Australia have tackled issues such as large caseloads, professional isolation, limited professional development and lack of autonomy. The last UK study discussed some of these issues, but was done in 2009. Since then the landscape of speech and language therapy has changed significantly, not least because of the effect of the recession and austerity on the health service. The vast majority of clinicians still work for the NHS, but most jobs have changed considerably. More clinicians than ever before also work outside of the NHS now.

There is research in related fields (eg nursing or teaching), which suggests that, to be most effective, practitioners should be well and healthy; but it's time there was current information about us – we count too! We owe it our clients, and ourselves, to be healthy. Do our employers look after us? Successful intervention for people with speech, language and communication needs has been argued to be cost effective to the nation.

My ambition is to share information about the occupational health of our workforce with the appropriate regulatory and professional bodies, as well as with employers, such as the NHS, and the universities where SLTs train. This could lead to a healthier workforce, less attrition and ultimately better outcomes for children, young people and adults who access our services. To do this, I will be conducting a survey, which will consist of a questionnaire that should take about 15 minutes to complete. People will also be asked if they'd be willing to be interviewed. The project will gain ethical approval from BCU, and any information provided will be kept confidential. The RCSLT has offered to help with dissemination of the results.

I hope as many SLTs as possible give their opinions so that we can get a comprehensive picture of our workforce. If you'd like to know more, please get in touch – see below for contact details. ■

Claire Ewan, **paediatric therapist. Email: Claire.Ewen@mail.bcu.ac.uk**

Appendix C11

Claire Ewen
Mon 16/04/2018 15:13
To: ████

Dear ███,

I hope that you are well. My questionnaire is now ready, so I've included the link. I hope you're still happy to fill it in!

Would you mind forwarding it to friends/colleagues who might be interested? I'd like to hear from as many people as interested...

Having just re-read your original email, I think that you have an interesting story to tell with regards to changes in the neuro-rehab setting. Perhaps you'd repeat them (copy them) into the 'anything else' question? The other option is to be interviewed - you can indicate your interest at the end of the questionnaire. Any information you provide in an interview will be anonymised; you won't be 'identifiable' in any way. Do have a think about it.

Here's the link:
Speech and Language Therapists Well-being Survey

Let me know if there are any problems.

Thank you again, and best wishes,
Claire

Claire Ewen
Speech and Language Therapist, & PhD Candidate
BA (Sp & H Th), MA (Ed), CertMRCSLT, HCPC Registered

From: ████
Sent: 04 February 2018 19:44:38
To: Claire Ewen
Subject: Re: Thank you

Dear Claire

Thank you for your prompt response. I would be willing to participate via questionnaire and interview if that would be helpful.

I look forward to hearing from you when you reach that stage,

Kind regards
███

On Sat, Feb 3, 2018 at 6:19 PM, Claire Ewen <Claire.Ewen@mail.bcu.ac.uk> wrote:

Dear ███,

Thank you so much for emailing me. It was very interesting to hear about your experiences in neuro-rehab (as a paediatric therapist I have little knowledge of the 'adult' world), which sound quite disheartening.

I would be most grateful if you were willing to take part in the research. You could participate by completing a questionnaire (which I'm just finalising after feedback from the pilot study). If willing, I could then do an interview to hear more about what is going on in your 'sector'. Any information will, of course, be kept entirely confidential, your name would not be known by anyone other than me.

Best wishes,
Claire

Claire Ewen

Speech and Language Therapist, & PhD Researcher
BA (Sp & H Th), MA (Ed), MRCSLT, MASLTIP, HCPC Registered

From:
Sent: 03 February 2018 17:05:51
To: Claire Ewen
Subject: Thank you

Dear Claire

Thank you for your recent article in the Bulletin reflecting the reality for many of us SALTs working in the NHS - it often seems the predominant narrative is about taking a positive stance, being innovative, etc and this needs balancing with the facts -

I work in neuro-rehab and despite sound evidence for long term cost-effective outcomes, our funded admissions have gone down from an initial 12 weeks with possible extensions, to typically 6-8 weeks with extension unlikely for severe aphasia and Cognitive Communication Difficulties.

Commissioners are variable in their experience, knowledge and skill - some unfortunately do not understand the client group and the potential benefits of rehab, unless they are concrete physio usually goals. It is incredibly stressful to work in a situation where such little credit is given to highly experienced professionals and evidence - we are told guidelines are 'aspirational' and have to compromise our professional practice.

Many senior colleagues have either already left to practise independently or are considering doing so.

If I can be of assistance, please let me know - I wish you all the best in your research

Kind regards

Speech and Language Therapist

Appendix C12

calsys.com | W: www

SPEECH AND LANGUAGE THERAPISTS WELL-BEING SURVEY

Claire Ewen, a practising SLT, is currently doing a survey that looks at the well-being (job satisfaction, stress) of SLTs working in the UK (with adults or children, in the NHS, other employment and independently). Would you be willing to help, by filling in an online questionnaire?

It would benefit you and your colleagues if you took part, and is a chance to shape future practice for the better. The survey is part of a PhD project. Full ethical approval has been gained from Birmingham City University and the project has the support of the RCSLT. All your details will be kept anonymous and confidential.

People who complete the questionnaire will, if they wish, be entered into a raffle - the prize being £200 towards a charity of the winner's choice. The questionnaire should take about 20min to complete.

In order to access the survey, please type the following address into your internet browser: **tinyurl.com/ybe2r5y7**

If you have any questions, please get in touch with Claire:

Claire.Ewen@mail.bcu.ac.uk

@SAClaire

Appendix C13

Changes made to the SLPSI

Firstly, instead of using the original descriptors for the Likert scale points, this study used: *never/seldom/sometimes/often/always*. Poché et al. (2004) first used these alternative descriptors in their study in 2004. The rationale for using these revised labels in the present study was due to face validity issues with the original scale (e.g. in response to the statement *I have too much work to do,* '*sometimes'* appears to be a more logical response than '*moderately noticeable'*. This change therefore improved the face validity of the questionnaire. Second, although the items on the SLPSI cover aspects that any SLT might be expected to deal with e.g. paperwork, caseload, administrative policies, the scale was developed for use with SLTs who are working in schools. Therefore, the word *students* was replaced with *clients/patients*, both terms that are widely used in the UK to describe service users. Another item was changed from *I don't feel like a member of the school* to *I don't feel like a member of the team in the setting where I work.* Finally, the words on four items were anglicized from American English:

I lack control over programmatic decisions was changed to *I lack control over service delivery models*

I lack professional improvement opportunities was changed to *I lack continuing professional development opportunities*

I work with too many severely involved clients was changed to *I work with too many clients with complex needs*

I experience discipline problems' was changed to *I am required to manage behaviour problems*

Appendix C14

Demographic profiles of pilot study participants

Pilot Participant	Recruited by	Employed/ Self-employed	Full time/part time	Sector/ employer
1	Known to researcher	Employed	Full time	NHS
2	Known to researcher	Employed	Part time (15hrs)	NHS
3	Known to researcher	Employed AND self-employed	Full time (22.5 – 45hrs, depending on how busy)	NHS/ Independent
4	Known to researcher	Self-employed (director of a private practice)	Full time	Independent
5	Known to researcher	Self-employed (solo practitioner)	Part time (28hrs)	Independent

Appendix C15

Feedback Form re: Pilot Questionnaire

Thank you for taking part in the pilot study for my research project regarding the occupational well-being of speech and language therapists. I should be very grateful if you could answer the questions below which will provide me with valuable feedback regarding the questionnaire and guide me in preparing the final version for the main study.

1. How long did it take you to complete the questionnaire?

20 minutes

2. Did you find the instructions clear to follow?

yes

3. Did you find any of the questions unclear or ambiguous? If so, please identify which ones and state why.

There was one on the last page that said, "do you want to say anything else?" but I could not click on it to respond

4. Did you object to answering any of the questions?

no

5. Did you feel any questions on a particular area were omitted?

Perhaps some about how much time spent in mandatory training and involvement in meetings for the NHS staff as this is often a source of frustration for them

6. Did you find the design of the questionnaire comprehensible and attractive?

Yes very good

7. Any other comments?

Thank you for completing this form. Please email to Claire.Ewen@mail.bcu.ac.uk

Appendix C16i-x

Results of assumption checking for statistical testing

i. Difference in well-being between JDCS groups: one-way MANOVA (p140)

The data was normally distributed, as assessed using a Normal Q-Q plot. There were 15 univariate and two multivariate outliers. MANOVA was conducted with and without the outliers and results for both tests were statistically significant. Outliers were therefore retained. There was no multi-collinearity, as assessed by Pearson's correlation ($r = -.453$, $p<.001$). There was a linear relationship between GJSS scores and GHQ-28 scores in each group, as assessed by scatterplot. There was not homogeneity of variance-covariance matrices, as assessed by Box's test of equality of covariance matrices (p,>001). Pillai's Trace was therefore used instead of Wilks' Lamda. because the group sizes were unequal (n=43, n=57, n=182, n=163). This also meant that Games-Howell post-hoc tests was used instead of Tukey.

ii. Additive effects of job demand, control and support on general job satisfaction: hierarchical multiple regression (p145)

There was linearity, as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was also independence of residuals, as assessed by a Durbin-Watson statistic of 1.953. A visual inspection of a plot of studentized residuals versus unstandardized predicted values revealed homoscedasticity in the data. No evidence of multicollinearity existed, as assessed by tolerance values greater than 0.1. There were no outliers: no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and no values for Cook's distance above 1. The assumption of normality was met, visually assessed by a P-P Plot.

iii. The contribution of bureaucratic restrictions and lack of professional support to job satisfaction: multiple regression analysis (p147)

During initial investigations, as to whether the assumptions for running a regression analysis were met, two items were highly correlated ($r = 0.79$, $p<.001$). These were:
I feel administrative policies limit my professional growth and

I feel administrative policies limit my effectiveness

The items were therefore combined by calculating a mean for both items and a new item was created, and labelled:
Administrative policies limit professional growth & effectiveness

In addition, two cases had studentized deleted residuals that were greater than 3 standard deviations from the mean. Removal of the two outliers were removed did not result in a change in significance, and they were therefore retained. All other assumptions were met.

iv. The interactive effects of job demand, control, and support on general job satisfaction – hierarchical multiple regression (p149)

All assumptions were met, apart from there being four outliers. The analysis was therefore conducted with and without the outliers to establish whether removal of the outliers had an effect on the statistical significance of the interaction of predictor variables to the outcome variable. While there was no difference in significance in any of the three models, or in the contribution of individual predictor variables, retention of the outliers created a statistically significant result where one did not exist if they were omitted. They were therefore removed prior to analysis.

v. Additive effects of job demand, control and support on general biopsychosocial well-being: hierarchical multiple regression (p150)

There was linearity, as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was also independence of residuals, as assessed by a Durbin-Watson statistic of 1.921. A visual inspection of a plot of studentized residuals versus unstandardized predicted values revealed homoscedasticity in the data. No evidence of multicollinearity existed, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and no values for Cook's distance above 1. The assumption of normality was met, as assessed by a P-P Plot.

vi. The interactive effects of job demand, control and support on general biopsychosocial well-being: hierarchical multiple regression (p158)

All assumptions were met, apart from there being six outliers. The analysis was therefore conducted with and without the outliers to establish whether removal of the outliers had an effect on statistical significance of the contribution of predictor variables to the outcome variable. There was no difference in significance in any of the three models, in the contribution of individual predictor variables, or in the contribution of the interaction between predictor variables at any level. Outliers were therefore retained.

vii. Well-being across employment sectors: one-way MANOVA (p166)

Preliminary assumption checking revealed that data was not normally distributed for any of the three groups on some of the variables measured, as assessed by viewing skewness and kurtosis. The data was therefore transformed using square root transformation. However, this transformation resulted in the variables that were initially normally distributed becoming non-normal. The original data was therefore retained, as MANOVA is fairly robust to deviations in normality.

There were univariate outliers as determined by box plots across all three groups, for all outcome variables. The outliers were removed and MANOVA was re-run in order to determine whether there was a meaningful difference in the results but as there wasn't (both were significant, both had a small effect size), the outliers were retained. There was one multivariate outlier, as assessed using the Mahalanobis distance. Because MANOVA is fairly robust to multivariate outliers if the sample size is large, this outlier was also retained. The relationship between job satisfaction and general biopsychosocial well-being, as assessed by scatterplot, was non-linear for the employed and portfolio groups but as all other relationship were linear, the analysis was run, with an acceptance that this would result in some loss of power (Laerd website).

There was no multicollinearity as assessed by Pearson correlation ($r = -.640$, $p<.01$ for the GJSS & SLPSI, $r = -.453$, $p<0.01$ for the GJSS & GHQ-28, $r = .615$ for the SPSLI & GHQ-28). Box's M test ($p<.001$) revealed heterogeneity of variance-covariance matrices. Because of this, and because of the unequal sample sizes, Pillai's Trace was used instead of Wilk's Lambda as the test statistic. Levene's Test of Homogeneity of Variance revealed that the GJSS was marginally heterogeneous ($p=.048$), which could have resulted in the

heterogeneity of the variance-covariance matrices. This meant that the Games-Howell post-hoc test was run, in place of the Tukey test

viii. Comparison of job satisfaction and general biopsychosocial well-being at T1 and T2: paired samples t-test (p168)

A paired samples t-test revealed that the increase in GJSS scores across time just reached statistical significance, t (285) = -2.04, p=.04, when outliers were removed. However, the exclusion of outliers should always be a last resort (Faraway, 2015). When the t-test was conducted on the data set and outliers were included, there was no statistically significant difference t (292) = -1.45, p=.15.

The increase in the GHQ-28 score across time was not statistically significant, t (294) = 1.16, p=.25, this was the case, both when including and excluding outliers. Outliers were therefore retained.

ix. The impact of change on job satisfaction and general biopsychosocial well-being: Three-way mixed MANOVA (p170)

The two between subject factors were (i) staying in a job v leaving a job and (ii) making a positive personal change v no positive personal change. The within-subject factor was a repeated measure i.e., over a 3-month period. Therefore, four groups existed within the analysis:

v. Those who were in the same job and had made no personal changes
vi. Those who were in the same job but had made a positive personal change
vii. Those who had left their job but no personal changes
viii. Those who had left their job and made a positive personal change

Assumption testing revealed that, for the four groups, multivariate normality existed for the first two groups on both GJSS scores and GHQ-28 scores (xxx) but not for the second two groups on either of these scores (xxx). However, MANOVA is fairly robust with respect to Type 1 error, even with small, uneven samples (Bray & Maxwell, 1995; Pituch & Stevens, 2016; Wienfurt, 1995). Analysis therefore proceeded. There were both univariate (n=13) and multivariate (n=8) outliers. The analysis was therefore conducted with and without the outliers to establish whether removal of the outliers had an effect on statistical

significance of the contribution of predictor variables to the outcome variable. There was no difference in significance in any of the three models, in the contribution of individual predictor variables, or in the contribution of the interaction between predictor variables at any level. Outliers were therefore retained. Visual inspection of scatterplots revealed linear relationships between the dependent variables for each group of the independent variable, and there was no multicollinearity. The variance of the dependent variables was equal between the groups of the between-subjects factors, and the variance of the differences between groups (within-subjects factors, i.e. the repeated measures) was equal – Greenhouse-Geisser and the Huynh-Feldt Epsilon values were both 1.000

x. Comparison of job satisfaction scores at T1 and T2 for those who changed jobs and those who remained in their jobs: independent samples t-tests (p170)

T1: There were no outliers in the data, as assessed by inspection of a boxplot. Job satisfaction scores for those who had remained in their jobs and those who had left were normally distributed, as assessed by Shapiro-Wilk's test ($p>.05$), and there was homogeneity of variances for job satisfaction scores for both groups, as assessed by Levene's test for equality of variances ($p=.532$).

T2: Assumption checking again revealed that there were no outliers in the data, as assessed by inspection of a boxplot. Job satisfaction scores for those who had remained in their jobs and those who had left were normally distributed, as assessed by Shapiro-Wilk's test ($p>.05$), and there was homogeneity of variances for job satisfaction scores for both groups, as assessed by Levene's test for equality of variances ($p=.631$).

Bray, J. H., & Maxwell, S. E. (1985). *Multivariate analysis of variance*. Thousand Oaks, CA: Sage

Maxwell, S. E., & Delaney, H. D. (2004). *Designing experiments and analyzing data: A model comparison perspective* (2nd ed.). New York, NY: Psychology Press.

Pituch, K. A., & Stevens, J. P. (2016). *Applied multivariate statistics for the social sciences* (6th ed.). New York, NY: Routledge

Weinfurt, K. P. (1995). Multivariate analysis of variance. In Grimm, L. G. & P. R. Yarnold (Ed.), *Reading and understanding multivariate statistics* (pp 245-276). Washington, DC: American Psychological Association

Appendix C17

Examples from the reflective diary

Reflection following qualitative analysis of the open-ended question on the survey (T1):

10 September 2018: Reading and re-reading the responses made by clinicians left me feeling very conflicted. I was touched by the fact that clinicians expressed appreciation of a study investigating their well-being. Sixteen respondents expressed their thanks that the research was taking place. Examples of statements include:

> *"Thank you for this opportunity to voice some of my underlying concerns. It feels like the elephant in the room for so many of us healthcare practitioners now." (78)*

> *"Thank you for highlighting the importance of well-being in SLT, it's come at a good time." (183)*

I wondered about whether these responses were possibly born from feelings of being undervalued or ignored. I also felt anger, sadness and worry. The initial reading showed that working in the NHS can cause harmful levels of stress; and that this contrasts with working privately – which was reported to be worthwhile, fulfilling and satisfying. Although this chimes with my own experiences it is at odds with my worldview, which I found quite distressing. I believe that communication is a basic human right and that anybody should be able to access the support that they need if they have difficulties. I strongly believe in the ideals of a welfare state, where healthcare is 'free at the point of access.' I also believe in the rights of workers to be well – not only physically, but emotionally and psychologically too. I don't think that the answer is for SLTs to all leave the NHS and work privately in order to be well but believe that SLTs in the NHS need to be listened to and supported. At this stage (and maybe not ever) I don't propose to know how to "fix things", but I think that the current 'defund to privatise' strategy that appears to be in evidence is amoral. This made me think about Chomsky's work, and I looked it up again. I also think that as SLTs we engage in unwitting collusion – we leave the NHS because we are so stressed and unwell and end up in tacit support of privatisation. I'm left feeling very aware of the fact that, whatever the final output of the PhD, I need to be very careful about not appearing

to support privatisation of our health service – this is not something that I believe in. I am also aware of the need to bracket these feelings in order to ensure that my preconceptions and values do not bias interviews that will take place in the next phase.

NOTES:

Noam Chomsky: text of his lecture The State-Corporate Complex: A Threat to Freedom and Survival, given at the University of Toronto, April 7, 2011 verifies this (emphasis mine):

"Social Security is actually in pretty good shape despite what everybody screams about. But if you can defund it, it won't be in good shape. And ***there is a standard technique of privatization, namely defund what you want to privatize****. Like when Thatcher wanted to defund the railroads,* ***first thing to do is defund them, then they don't work and people get angry and they want a change. You say okay, privatize them*** *and then they get worse".*

Retrieved from: https://chomsky.info/20110407-2/

Granter, H., & Hyde, M. (2011). "Welcome to the NHS"; normalized intensity and healthcare work.

Reflection following qualitative analysis of the open-ended question on the survey (T2):

24 October 2018: It was interesting that a number of SLTs had made positive personal changes between completing the survey at T1 and the survey at T2. It made me wonder whether any of the changes had been prompted simply by filling in the first survey. SLTs are trained to be reflective (in terms of their clinical practice) and it seems reasonable to suggest that, having filled in the first survey, many reflected on their practices regarding their own well-being. This might well have resulted in them making the positive personal changes that they described e.g. going home on time, changing their attitudes to work, doing more exercise. The possibility that this was the case led me to believe that this might be a form, albeit unmeasurable, of impact. My overall wish is that this research has a positive impact on the well-being of the SLT workforce, and I wondered whether perhaps completing the first survey raised awareness among SLTs of their own well-being, which possibly resulted in improved health.

Reflection following quantitative analysis of the survey (T2):

14 November 2018: I was disappointed to find that the quantitative analysis of the longitudinal study did not support my thoughts following qualitative analysis of the personal changes made by participants between the surveys at T1 and T2 i.e. that making a personal change as a result of completing the first survey might have improved well-being. The quantitative analysis revealed that making a personal change had no effect either on job satisfaction or on general well-being. However, I am beginning to realise that perhaps statistics don't always provide the depth and nuance that qualitative research does – although participants who had made changes were not asked to comment on how they felt with regards to their stress/well-being, some wrote comments that indicated that, subjectively, they felt better e.g. that exercising made them feel 'good', that they were less stressed, that they had a better work/life balance, that exercise and yoga benefitted their mental health. I am interested to see what the interviews will reveal – although I won't specifically be asking about changes made, perhaps this is something that participants will mention. Again, I need to be careful to bracket my own thoughts/feelings.

Reflective diary extract, prior to the interviews beginning:

28 January 2019: I have been thinking a lot about bracketing (which I know cannot be fully achieved) and what my potential bias might be. Before starting the project – before the survey, I think that my own experience (of being stressed) resulted in a presupposition that others would feel the same. The results from the survey meant those 'fore-structures' were further shaped and altered. The results indicated that SLTs seem to have 'average' satisfaction and 'moderate' stress – on the other hand, just over half the sample failed the general biopsychosocial health screen. It makes me reflect on the fact that this area is more complex than I initially thought, and my thoughts are that I want to know more about what SLTs are experiencing and feeling. The numbers alone don't seem to answer my questions. So, how have my assumptions changed? I think that the concepts I'm looking at are more nuanced, more subtle than I previously realised, and I'm keen to explore what others think.

Reflective diary extract, mid-way through the interviews:

23 February 2019: I have completed nine interviews and I'm exhausted. I have been travelling all over the country – this week I spent 13 hours driving to three interviews, and this is not an unusual week. I am having to work really hard to engage in post-interview reflection, after a day that has involved driving for hours in addition to interviewing the participant. So, I'm physically tired, and feel psychologically drained. However, I am enjoying talking to SLTs and hearing about their experiences and feelings. So far, all have told me about situations/events that have generated feelings of empathy and concern in me and this too is emotionally tiring. I feel that some of my assumptions have been confirmed and worry about this a little – am I looking for interpretations that are aligned with my original ideas? I don't think this is the case – for example, participants are talking about things that I hadn't thought of beforehand, which means that themes are emerging from their viewpoints, not mine e.g. the job as a battle. In addition, I am trying really hard to ensure that I am open to what they want to say, and to not lead participants.

Reflection following the interview with Susan

Susan had been qualified for 5 years – she works in the NHS as a paediatric (early years) clinician with an interest in ASD. She thought carefully before answering questions and used a phrase that I found interesting – 'stolen autonomy'. She spoke about having a very supportive team, and said, 'I love my job even though it's horrible'. She also talked about having cognitive dissonance – she felt that she often had to do things in a way that she thought was ineffective. She mentioned the emotional stresses of the job and gave an example of a father crying on the phone. In addition, she spoke about not being a Band 7, which was a 'sore point' and explained that she was doing many of the same tasks as the Band 8a therapists e.g. carrying out ADOS assessments. My two main thoughts following the interview are: Firstly, that I feel she had shared some information that I found thought-provoking – I wonder whether I might need to guard against 'overusing' information that she had provided. Secondly, I'm a little worried about whether the recording will be audible – we met in a café, which started off quietly, but 2 minutes after we began a party of 4 very loud men sat down and spent the hour really enjoying themselves and making a lot of noise.

Reflection following analysis of the interview with Susan

Susan appeared to be very aware of her own well-being and took responsibility for maintaining her well-being. She had strategies that helped her to ensure she is well but admitted to struggling at times. She said that she felt her well-being at work and home were essentially the same thing – but that any struggles she has stem from work (when having to work 'very hard'). When talking about 'mini-burnouts' she touched on emotional exhaustion and detachment, mentioning a loss of 'professional curiosity', 'losing interest in work' and that she is 'exhausted' and 'can't be bothered.' She talked about a particular situation where she felt side-lined, and that this impacted on her self-esteem, and made her feel worthless ('rubbish'). Susan was passionate about being an SLT, saying that she was 'made to be a speech therapist'. The language she used when talking about responses to situation was strong: e.g. 'unbearably angry,' and 'horrific.' She talked about the values and beliefs that contribute to her professional identity e.g. a sense of social responsibility and the need to be emotionally invested in her work. There was a sense of Susan feeling she was involved in a battle – 'fighting the good fight.' There seemed to be some conflict – she spoke about loving her job 'even though it's horrible.' Susan also demonstrated her willingness to take responsibility for decisions made at work, when talking about 'stolen' autonomy – something that she does in order to circumvent service constraints that she feels are inappropriate. The lack of funding or the use of funding that is not judicious was an issue for Susan. She also talked about resilience, but felt that this happens within a context, and can be difficult if there is no time built in, in which to 'recover.' Finally, Susan talked about cognitive dissonance and what she does to try to overcome this e.g. becoming involved in other projects. Themes that appeared to be emerging from Susan's account appeared to be: taking responsibility for her well-being and her clinical practice, conflict around her feelings about her job, and cognitive dissonance (along with attempts to resolve this).

Appendix C18

The underlying philosophical theories that contribute to IPA

Phenomenology

Husserl (1859-1938) established a focus on the structure of consciousness and experience and stressed the importance of going back to 'the thing' – the object/memory/imagination (in the case of IPA, the 'lived experience'). His emphasis on intentionality (i.e. that consciousness is always oriented towards 'the thing') and on the central role that reflection plays in our attempts to make meaning of our experiences have been influential. Husserl also espoused 'bracketing' – suspending judgment about the 'taken for granted' world and focusing on the analysis of the experience itself – claiming that this phenomenological reductionism would lead a researcher away from distraction toward the essence of 'the thing'. From Heidegger (1889-1976), IPA is influenced by the concepts of *dasein* ('being with' or 'being in') and *geworfenheit* ('thrown into' the world) i.e. the focus shifts from the individual to a more worldly perspective – existence is always in the context of others, and in a pre-existing world from which we cannot meaningfully extract ourselves. Intersubjectivity is important too – the fact that we have shared, overlapping relations with others. Merleau-Ponty (1908-1961) shifts the focus to embodiment, so that situations are *lived through* for one person, while *displayed for* another. Finally, Sartre (1905-1980) emphasises the development of being, and the role of 'nothingness' implying that that which is absent is as important as that which is present in shaping our understanding of the world. So, in summary, IPA is a reflective process that attempts to understand the lived experience of a person as an embodied individual in the context of the world and in relation to others, and who is continually developing, or 'becoming themselves'.

Hermeneutics

The attempt at 'understanding' brings one to the second influence on IPA; hermeneutics. Hermeneutics, the theory of interpretation, has been influenced by, among others, Schleiemacher, Husserl, Heiddeger, and Gadamer. Schleiermacher (1768-1834) focused on understanding both the text (talk) and writer (speaker) and maintained that an analyst could understand the writer (speaker) better than that writer (speaker) understands themselves. This claim offered IPA the possibility that the researcher could provide insights which exceed or subsume explicit claims of a participant. Three steps achieve

this aim: the systematic, detailed analysis of data, the connection of data from the individual to the larger data set, and a dialogue with psychological theory (Smith et al, 2009). The interpretative nature of phenomenology was also emphasised by Heidegger, who asserted that ‘fore-structure’ (prior experiences, assumptions and preconceptions) is always present. This allowed for the reinterpretation of bracketing so that, in IPA, it becomes a cyclical process that can only partly be achieved. Finally, Gadamer (1900-2002) furthered this view of the cyclical process by drawing attention to the fact that preconceptions may be influenced by the interpretation of the experience or may only emerge through the process so that openness throughout the experience is essential. IPA embraces both the double hermeneutic, where the participant interprets their experience and the researcher then interprets the information provided by the participant, and the hermeneutic loop – the fact that we need to understand the whole through its constituent parts and the parts in terms of their relationship to the whole.

Idiography

The third major influence of IPA is idiography, the concern with the particular (Smith et al, 2009). Focus on the particular (and the particular should not be confused with the individual, although the individual provides access to the particular) is achieved in two ways. The first is by depth of analysis and the second is by being ‘committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context’ (Smith, et al, 2009, p29).

Appendix C19

INTERVIEW SCHEDULE: TOPICS & QUESTIONS

A. Opener:

1. Just to start, I'm interested to know – why did you agree to be interviewed?

B. About the person – how they view themselves:

2. I'd like to start at the beginning of your career…

   a. How did you get in to being an SLT?

   b. How do you feel about being an SLT?

   c. What do you think are the qualities that are required to do your job?

C. About 'well-being'

As you know, this project is about SLT well-being.

3. What does the term 'well-being' mean to you?

   [Prompts
   a. How aware are you of your own well-being? Can you give me an example?
   b. What about your psychological or emotional well-being?
   c. Do you think there are things at work that put your well-being at risk (please tell me about these)?
   d. Is it accepted that these things are usual for the job?
   e. What do you think should be accepted – and not accepted?
   f. Do you think it's typical to feel stressed in this profession?
   g. What about other SLTs that you know – are they more or less stressed?]

D. About the job

Recap where they work (get this from the questionnaire data)

4. Tell me about working for the NHS as an organisation/in the independent sector.

5. Tell me about how you came to work in the sector that you do.

   [Prompts

   a. Have you worked there since you qualified?
   b. What motivates you to stay/motivated you to leave?
   c. Would you ever consider a move (why/why not?)/ tell me about the move?
   d. Is there anything that you like about your job? Tell me about that.
   e. Is there anything that frustrates you/is hard? Tell me about that.]

6. The survey asked about control – I'd like to focus on autonomy. Can you please tell me about any autonomy that you have in your job?

   [Prompts

   a. What sort of situations in your job do you have control over?
   b. What encourages it?
   c. What doesn't encourage it?]

7. The survey also asked about being supported. I'd like to ask about supervision. What does your supervision usually cover?

   [Prompts:

   a. Do you get to talk about feelings in supervision? Can you tell me about that?
   b. What about how to manage stress or anxiety?
   c. Is there any other support for managing stress or anxiety – or any other emotional reactions to your work?]

8. What else do you think could be done to support SLTs?

9. Would you be able to give me an example of a time when things got too much for you and the effect that that had on you?

E. Closing

10. Given everything we've discussed, what stands out at the most important issue to you? Is there anything that we haven't raised that you'd like to comment on?

Appendix C20

DEBRIEFING SHEET

SUMMARY OF PROJECT

This study is looking at the well-being of speech and language therapists in the UK. The study investigates elements of well-being such as satisfaction, stress and anxiety. We are interested in your experiences of working as an SLT, and how your work is associated with varying levels of wellbeing and health issues – both positive and negative. Job satisfaction and stress has been researched in some detail, but the majority of research that looks at SLTs has taken place outside of the UK. There is little up-to-date information about how UK SLTs are doing.

HELP WITH FEELINGS OF DISTRESS OR ANXIETY

If you have found or find in the future that you are distressed by the subjects raised during the interview, you are advised to contact your GP. Alternatively, you can receive confidential advice from **The Samaritans**.
https://www.samaritans.org
(The Samaritans do not deal only with people who are having suicidal thoughts but will talk to you about anything that may be causing you distress or anxiety).

KEEPING IN TOUCH

You can join a mailing list to be told about the results of this study and any publications it is published in. Please let the researcher (Claire Ewen, see details below) know if you want to be added to the mailing list. The email address that you provided during Phase 1 of the study will be used. You can withdraw from the study at any time up to 2 weeks after your interview. To do this you will need to contact the researcher, by email or by mobile phone (if you phone you will need to use your pseudonym).

ANY MORE QUESTIONS?

We hope that you enjoyed participating in this study. If you have any further questions, please feel free to contact the researcher at the address below.

The researcher is **Claire Ewen** and you should try to contact her in the first instance with any queries. She can be contacted at
Claire.ewen@mail.bcu.ac.uk
Or voicemail/text on **07905 721 032**

The supervisors can also be contacted. They are:
Professor Craig Jackson: Craig.jackson@bcu.ac.uk
Dr John Galvin: John.galvin@bcu.ac.uk
Dr Helen Jenkins: Helen.Jenkins@bcu.ac.uk

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law & Social Sciences faculty research ethics committee directly at
blssethics@bcu.ac.uk

Appendix C21

234 C: Yeah, so basically, you've got specific skills (S: yes) and you want to be using those
235 skills (S: exactly). But you're spending some of your time using skills that you
236 shouldn't really be expected to have.
237
238 S: Or if I was expected to use them, I think there should be some training [laughs] (C:
239 okay, yeah, yeah) Because I find it so difficult.
240
241 C: Right. Yeah, that makes sense. I understand. So, tell me a bit more about working in
242 the NHS. Have you always worked in the NHS?
243
244 S: Since I've been a speech therapist.
245
246 C: And what about working in the NHS do you really like?
247
248 S: It just feels fair. It feels like you're doing something, like morally it feels nice. You
249 know, and the NHS is really, it feels under threat and, so I feel like I'm fighting the
250 good fight. And I feel, like, roused by it. Um, and...
251
252 C: So that motivates you to stay.
253
254 S: Yeah, exactly. To stay. Exactly. And also, I like a sense of, this is horrible, I feel like a
255 bit superior? because [inhales] um, so every day I go to work and at some point I go,
256 'This is awful, I hate the NHS, I'm going to leave.' And then I think, 'Well, it can't just
257 be left with people that find it acceptable,' Do you know what I meant? That would
258 be terrible. [laughs] Um, so, yeah.
259
260 C: So you're saying that the NHS *needs* to have people that *don't* find it acceptable?
261
262 S: Exactly that, yeah.
263
264 C: Because?
265
266 S: Because, because it *is* actually unacceptable, like the care package we give is too
267 small, and we're not meeting the needs of people, and, like although I hate it, um,
268 like, and it's like a big cognitive dissonance, like every day, like, 'Why am I doing this,
269 because I don't think it's right?' Um, but then I know that I'm also, like I'm working
270 on the improvement project and I'm, like I'm trying different things and I'm pushing
271 really hard, and, and that's better than somebody that would just go in and give this
272 really small package, and be like, 'Oh right, well thank you, bye,'
273
274 C: That makes sense. So would you ever consider moving from the NHS?
275
276 S: Yeah. Um, so, I would move, I think I will at some point move from the NHS, um, so
277 things I've considered, um, reducing to part-time in the NHS and doing part-time
278 private work, just so that I could have, like a longer, like more fulfilling relationship
279 with a family (C: yeah) Um, so I thought that that would meet some of my needs for
280 the reasons that I enjoy the job, but then I could be in the NHS. And also, I'd develop

Handwritten annotations:
- If expected to do something, needs training
- NHS — likes: moral, feels fair
- Her values: SELF
- → Believes in the NHS, but hates it.
- CONFLICT
- why am I doing this? I don't think its right.
- Cognitive dissonance.
- hates it: not meeting needs of people: unacceptable
- She is trying. Better than someone who doesn't care
- would still work part time in NHS.
- has considered private work: would meet needs (relationships; emotional investment) + develop skills

6

Appendix C22

Details of changes made between T1 and T2

One of the aims of the second questionnaire, sent to participants in September 2018 was to investigate any changes that participants had made during the three-month period since they had completed the first survey. Two questions gathered information about changes:

a. "Are you still in the same job that you were when you answered the first questionnaire between April and July 2018?"
b. "Have you personally made any changes that you believe have altered your well-being?"

Of the 295 respondents at T2, a total of 142 people reported that they had made a change between T1 and T2. Table C22.1 provides details of these changes.

Table C22.1. Changes made between T1 and T2 (*n*=142)

Change made	**Participants *n* (%)**
No change	153 (52)
Same job, made a positive personal change since T1	122 (41)
Left the job they were in at T1, no personal change	7 (2)
Left the job AND made a positive personal change since T1	13 (5)

Note. Of the 135 who stated that they had made personal changes, 134 were positive.

Sixty-three percent (n=89) of all changes made were related to participants' jobs – the participant had either left the job they were in at T1 and/or they had made a positive personal change that was specific to their working life. Table C22.2 provides a breakdown of the work-related changes that participants had made since T1.

Table C22.2. Work-related changes (n=89)

Change	Details	*n*
No longer in the job that they had held at T1 (n=20)	Not working	2
	Retired	1
	Moved jobs, still employed by the NHS	9
	Employed by organisation other than the NHS	4
	Moved to self-employment	2
	Partly employed by the NHS, partly self-employed	1
	Still working, but not as an SLT	1
Changes to hours worked/structure of hours worked (n=48)	Reduced time (e.g. taken on less work as ISLT, smaller caseload, working fewer hours as employee, handed in notice at one of her jobs)	11
	Increased time	2
	Working contracted hours (don't get in early, leave on time, take a lunch break, don't bring work home, having a 'real holiday')	30
	Changed to flexible working hours (to enable participant to drop their child at pre-school, working 4 days over 3)	4
	Started taking work home (as was stressed about unfinished work)	*1*
Changes to tasks/structure of tasks at work (n=17)	Reorganised or reallocation of tasks within work (e.g. time for admin, booking in fewer clients, "not 'own' tasks or situation that should not be mine or mine alone", "not taking on clients who I don't feel	16

	comfortable or confident with" rearrange rota, stopped taking new enquiries, reduced clinical workload, changing record keeping system, delegated tasks, role change)	
	Stepped down from management role	1
Sought support at work (n=3)	Discussed issues with manager	2
	Asked for support with a complex case	1
Consciously changed attitude (n=7)	Not worrying about incomplete work, "more definite in what I can achieve and what I can't", "changed outlook" towards work, "no longer putting pressure on myself, being aware that breaches on the waiting list demonstrate a team that may be understaffed rather than a team that is not achieving good results", "adopted a 'good enough' attitude v seeking perfection", established boundaries between herself and clients [parents of children], adapted to the situation	7
Other (n=3)	Maternity leave	2
	Resigned and currently working out notice period	1

Note. Summing the responses in different themes does not equate to the total number of respondents that made comments, as some respondents reported more than one change. Negative changes are italicized.

Changes outside of work (positive personal changes)

Positive personal changes were described by 135 respondents. As detailed above, 89 of these were work-related. Other comments described changes that appeared to be aimed at improving biopsychosocial well-being. They included direct changes to physical activity

and/or diet, as well as changes aimed specifically at improving psychological and social well-being. Some participants made work-related changes and other positive personal changes. All the non-work-related changes were positive. The following section provides a detailed breakdown of respondents. Table C22.3 provides a breakdown of the positive personal changes that participants had made since T1.

Table C22.3. Positive personal changes (*n*=68)

Personal change made	Examples of changes
General Health and Well-being (*n*=2)	Support through work (a discussion that provided reflection, a 5-session health and well-being course)
Physical health – exercise and diet (*n*=63)	More exercise e.g. running, cycling, walking, going to a gym Better diet, more regular sleep patterns, reducing alcohol intake
Mental health (*n*=18)	Mindfulness, meditation, therapy/counselling/coaching Taking anti-depressants
Taking time for themselves outside of work (*n*=10)	Art classes, redecorating, booking a summer holiday, reading, baking, reducing commitments to increase leisure time
Connecting with others (*n*=9)	Spending more time with families & friends, ending relationships
Religion (*n*=2)	Praying, taken an interest in Buddhism

Note: Summing the responses in different themes does not equate to the total number of respondents that made comments, as some respondents reported more than one change.

Appendix D1

Qualitative content analysis of the open-ended question at T1.

The last item on the questionnaire was, “Finally, is there anything else you would like to say?” Directed qualitative content analysis was used to explore this data.
Of the 658 respondents, 30.55% (n=201) answered the final question. Of these, 39 responses were either clarification of replies to earlier questions, comments about difficulties with the questionnaire, or general feedback about the study. These responses were eliminated before analysis. Employment sectors that the 162 remaining participants worked in is presented in Table D1.1.

Table D1.1. Employment sector of respondents to the open-ended item

Employment sector	Number of responses (%)
Occupationally employed: in the NHS	116 (72)
Occupationally employed: outside of the NHS	15 (9)
Self-employed	20 (12)
Partly employed, partly self-employed	6 (4)
No longer working	5 (3)

Both those employed in the NHS, and those employed outside it, described similar psychosocial working environments, and had comparable concerns regarding their well-being. There were some differences in the comments from those who were self-employed, and where these existed, they are highlighted in the subsequent sections.

The following key concepts from the literature were used as initial categories:

1. Job satisfaction
2. Stress/burnout
3. Demand/effort, control, support, and reward
4. Biopsychosocial consequences of stress

A sizeable amount of information did not fit into the a-priori codes, and new codes were therefore established during analysis:

1. The contribution of personal life to stress
2. Feeling understood/being valued
3. Descriptions of the self, individual differences

Finally, codes were reviewed, and four themes were identified. These are detailed in Table D1.2

Table D1.2. Themes identified in the open-ended responses from participants

Theme	Sub-theme	Number of participants commenting
Theme 1: The psychosocial work environment	1.1 Demands	55
	1.2 Control	17
	1.3 Support	34
	1.4 Reward: feeling understood/being valued and remuneration.	20
Theme 2: Broader influences on well-being	2.1 Individual differences, personal lives	23
	2.2 Descriptions of self and a mismatch in ideals	8
Theme 3: Occupational well-being	3.1 Loving the job	25
	3.2 Stress	51

Theme 4: The biopsychosocial consequences of stress	4.1 Physical consequences	5
	4.2 Psychological and social consequences	37
	4.3 Behavioural consequences	30

Note. n=162

1. **Theme 1: The psychosocial work environment.**

1.1. Demands.

Demands mentioned by participants included the quantity of work, large caseloads (ID14, ID66, ID559, ID406), unreasonable administrative demands (ID26), complex clients (ID219, ID257) and a "*heavy emotional load that leaves us as professionals under (sic)"* (ID385). Others commented on work pressure related to demands, e.g., "*under pressure to meet targets*" (ID469), "*pressure to just assess and advise*" (ID164), "*constant pressure on beds*" (ID148) and a pressure to discharge service-users: "*get patients out of hospital quickly",* ID415). Psychological and emotional demands were described, as were the expectations placed on SLTs:

> *"…you get competing demands for your thinly stretched attention every single moment of the day, or shouted at by patients, or carers crying, or ignored by managers (a fairly typical week)." (ID196)*
>
> *"…expectations are often way higher than are necessary (in the sense of expecting us to be all things to all people, doing all the jobs of everyone around us, including teaching, SENCOing, etc.), and thanks are thin on the ground…I think we're expected to be sisters of mercy and vocational, working way over our hours, and going above and beyond the call of duty, delivering a Rolls Royce service…"* (ID244*)*

The figurative language employed by the above participant contrasts a very human response to need ('*sisters of mercy'*) directly with more machine-like perfection ('*Rolls Royce service'*). In addition, '*going above and beyond the call of duty'*, is evocative of

battle. These comments point to the conflict experienced by the respondent, whose use of language reveals a struggle between the expectation to be both compassionate and perfect, within in a potentially hostile setting.

Some spoke of a lack of time ("*The job is very stressful and demanding; there are too many children to see and not enough time/resources to see them all…"* ID615) and others mentioned difficulty demonstrating the impact of what they do due to target-driven services: "*Services are…target led and do not allow the profession to show managers or the public the value we can bring to patients and their families*" (ID11). There was some indication that SLTs are resigned to the way that the NHS operates, with one respondent stating, "*No matter how high the demands are, we work together to give the best possible outcomes for patients. That's what the NHS is all about! :)*" (ID615). Adding a smile to her comment, might indicate that this particular SLT would like to be viewed as positive and that NHS culture was that she meet any demands placed on her.

Those in management roles commented on the additional demand associated with providing line management, stating that it is "*challenging*" (ID80). Management roles have expanded to include overseeing other health services as well as SLT, which results in "*dissatisfaction in having very little time now for SLT leadership*" (ID67). Having the additional responsibility of supporting other employees sometimes impacted negatively on the health of the manager ("*…the need to support other staff (has) a significant impact on own personal well-being*", ID140).

1.2. Control.

Self-employed SLTs described their autonomy e.g. "*in control of what I do"* (ID60), "*The ability to clinically provide what I feel the client and family need based on my professional assessment*" (ID83) which enabled them to effect change *("…more control over interventions I can provide, more regularly feeling like I can help*" ID404). One participant described her positive self-esteem as a clinician that had resulted from seeing the impact of her work with clients, and the skill discretion afforded her through her job:

“*I'm good at it, clients make good progress, families are happy. I chose to become self-employed so that I could continue developing my therapeutic skills, enjoy the intellectual stimulation and challenge of analysing and reflecting on therapy in simple and complex cases, and provide evidence-based therapy*.” (ID13)

Descriptions of control by the self-employed SLTs contrasted sharply with NHS SLTs, who reported a lack of autonomy caused by service delivery pressures, leaving them feeling that their skills were not valued. Examples of participant statements include:

“*It’s difficult to follow my own professional decisions*” (ID290)
“*pressure to discharge…difficult to follow my own professional decisions*” (ID290)
“*focus on productivity contacts instead of clinical quality*” (ID210)
“*clinical judgement not (being) valued*” (ID32)

1.3. Support.

Around a third of participants commenting on support mentioned issues such as a lack of staffing (*“…there are not enough staff at the coal face even though our managers say we are fully staffed…*” ID219). There were also reports of cuts to budgets, with 16 respondents commenting on this. There was some sense that these cuts were not always made in a transparent fashion: “*Hidden staffing cuts (i.e., not re-advertising vacant posts) are destroying our service”* (ID258). A lack of support sometimes had a detrimental effect on continuing professional development. Furthermore, there was a feeling that Clinical Commissioning Groups (CCGs) made budgetary decisions despite lacking clinical knowledge of speech and language therapy (“*Pressures have increased recently from CCGs who make the funding decision regarding patients neurorehab but lack the clinical knowledge.”* ID273).

The ability to demonstrate the value of speech and language therapy was again mentioned, this time in the context of being unsupported by an employer and lacking resources.

> *"There is currently no training budget so we must self-fund any training we wish to attend, which is disgraceful."* (ID384)
>
> *"I feel my employer is not bothered about the service and unable to see the benefits of SLT however through lack of resources/time/staffing etc I am struggling to promote the service and show these benefits, e.g., through audit etc."* (ID415)

Some responses referred to a scarcity of support without providing detail, using phrases such as *'I have found it a high demand low support job'* (ID273). Others were more specific, referring to a lack of emotional support *("There is nowhere near enough emotional and practical support…"* ID218) and directly to supervision *("…ineffective supervision…*" ID360). A combination of a number of things could lead to difficulties: *"…have recently found with the combined lack of support and lack of recognition, no training and little supervision that I am struggling.*" (ID333). In addition, workplaces could foster an appearance of support, while not actually providing support: ""…*I feel trapped in a system where any problems you raise are just swept away with 'We know it's hard…but you can only do what you do'. We are just told to read the occupational health website or to learn to be 'more resilient.'*" (ID96).

When SLTs do make an effort to support each other, this shifts the weight of demand from one person to another:

> *"Another supportive factor is my very supportive colleague… we help one another… she takes on my cases…I also worry about her caseload as sometimes she has relieved pressure by taking patients off me…"* (ID559)

There were comments about the support received by managers specifically. Some respondents felt that SLTs did not provide effective leadership e.g. SLTs *"…lack skills and experience in managing others*" (ID360), "…*ignored by managers*" (ID96), "…*very poor leadership*" (ID273) and "…*line management constantly quote 'service need' and disregard employment (legal) rights of therapists*" (ID72).

There was some reference to wider NHS management: *"…mismanagement of the service by top (non SLT) managers resulted in a breakdown of a successful, well run service and poorer quality of work life*" (ID196). Others commented on management by non-SLTs *"…I have a good relationship with my team, however, do not have a good relationship with my managers who are not SLTs*" (ID289).

Managers themselves appeared to receive little support e.g. "*I am the lead of a service…there is very little senior support and no supervision*." (ID51). This lack of support could result in feeling isolated in the role: *"Team I work with is very supportive but highly isolated in my service manager role which adds significant pressures*" (ID134).

A small number of the comments (n=6) about support were positive. The benefits of support, in terms of its preventative role in combatting stress were described by one respondent: "*Without the support I have in work I think I could easily become overwhelmed and stressed"* (ID321). Another linked being supported to feeling positive about the job: *"I really do enjoy my job and feel well supported"* (ID62).

1.4. Reward: feeling understood/being valued and remuneration.

An SLT who had made the decision to leave her job encapsulated the feelings of some of the participants in this study: *"Working for 10 years in one trust I have had very little reward or real recognition."* (ID333). Reward was primarily discussed in terms of feeling understood and valued, but also included comments about pay.

1.4.1. Feeling understood and being valued.

Respondents referred directly to being "*poorly understood*" (ID384), "…*no recognition of our skills and training by society and the governmen*t" (ID44) or of there being "*little, if any, understanding*" (ID258) about the profession. Comments such as "*other people think that SLT is a nice cushy job where you just talk to people or thicken their drinks*" (ID96) and that "*tasks take far longer than 'agreed' by management*" (ID563) also pointed to a lack of understanding across both the public and supervisors. Furthermore, this extended to policy makers: "*The Profession suffers from a lack of understanding and interest from funding bodies and government*" (ID60).

Linked to this lack of understanding was the feeling of being undervalued. Some respondents referred to a lack of, or no recognition. Comments included: "*no recognition for your hard work*" (ID226), "*no recognition of our skills and training by society and the government"* (ID44), as well as generally stating, "*lack of recognition*" (ID333). SLTs reported being undervalued by the service in which they worked *("My service made me feel undervalued,"* ID229). In addition, NHS employees could feel that the profession, or service provided, was undervalued by the NHS: '…*feel that the organisation does not value the profession and skills"* (ID7). Furthermore, SLTs sometimes felt undervalued by other services, such as education e.g., *"…sometimes the schools that I go to don't book a room for me or are lacking in space therefore I have to work e.g., in the staff's kitchen."* (ID435). Two participants' comments referred to the omission in the media, of the work that SLTs do: "*A bit more recognition in the mainstream media would be nice too. It's frustrating when the health service is referred to in terms of just 'nurses and doctors*'" (ID559) and *"I feel there is a lack of understanding of speech therapy in the general population; media etc. always focus on 'doctors and nurses', even when reporting on situations where a speech therapist must have been involved."* (ID337).

The intensity of feeling undervalued was captured by one respondent who worked as SLT bank staff (i.e., through one of the NHS temporary staffing services). She said, "*I do not feel I am seen as a human being*" (ID563). This reference to dehumanisation is a stark comment about the way in which the system has undermined the individuality of this particular respondent, reducing her to an abstraction. Another NHS SLT described the consequence of not being understood or valued: "*SLTs are attacked from every angle in and outwith (sic) the profession. This is a 'tragedy' given the skills and knowledge that they hold*." (ID184). Once more, the language used is noteworthy: 'attacked' implies a conscious condemnation or reproval of the workforce – and again alludes to battle – with the result being catastrophic – a 'tragedy' for SLTs.

1.4.2. Remuneration.

In addition to general comments about feeling undervalued, perceived incommensurate salary was explicitly linked to feeling unappreciated e.g., "*Recently been down banded so feel that the organisation does not value the profession and skills."* (ID7). Poor pay was, at times, viewed as a reason for dissatisfaction e.g., "*Salary is the biggest issue. Income very much worse in real terms…Feel salary should be much higher and government taking*

advantage of us." (ID44), "*This is a very high-pressure job without the pay or recognition it deserves*" (ID442). One participant referred specifically to the Enderby v Frenchay Health Authority (1993) legal case, which achieved pay parity for SLTs with clinical psychologists:

> *"The case that was won re equal pay with Clinical Psychology is now null and void which is disheartening when work pressures and case complexity is (sic) increasing" (ID257)*

In contrast, one respondent (ID245) reported that the inability to find work outside the NHS that would be commensurate with her current salary, encouraged her to stay in her job. While this might point to salary as being a positive element of work in the NHS, she used the phrase '*feel trapped'*, suggesting an inability to escape an unpleasant situation, and suggesting that salary alone might not lead to satisfaction. This statement regarding the differences in remuneration between the NHS and elsewhere, and the part that salary might play in feeling satisfied, aligns with those made by self-employed SLTs. Some self-employed SLTs reported that work was less secure and that they earned less than their NHS contemporaries, however, these comments were not indicative of a source of dissatisfaction; "*I am self-employed and work part time on my own schedule, which accounts for my high job satisfaction and low salary!"* (ID81), *"I have been considerably happier and less stressed since leaving the NHS despite less secure work and lower earnings"* (ID176).

2. **Theme 2: Broader influences on well-being.**

2.1. Individual differences and personal lives.

There was some indication that respondents took responsibility for any negative feelings they may have, citing their own individual dispositions as the source of their feelings. One person described this as follows: "*Depends on people's personalities, how stressed they get. Lots of people in the same job as me are always stressed. But I am just a relaxed person,*" (ID542). Another described being "*possibly over conscientious*" (ID269). However, there was evidence of tension between accepting that feelings were due to disposition and acknowledging the role of the job in contributing to those feelings. One

respondent was reluctant to ascribe the cause for her feelings as the situation at work, despite acknowledging the role that work demands might play:

> *"I am receiving treatment for depression currently however feel work is not a particularly big factor in this, aside from the workload and working overtime sometimes"* (ID406).

Another mentioned her own personality as being the cause of 'problems', but then went on to frame this within the requirements of the job:

> *"I think some of my wellbeing problems stem from a 'perfectionist' approach whereby I am frustrated and disappointed by being unable to provide the quality of input I deem effective or appropriate (e.g., what the evidence base shows to be appropriate dosage)." (ID559)*

Evidenced-based practice is a cornerstone of clinical work and the foundation of providing effective intervention. The above respondent's statement referred to the inability to achieve what is deemed clinically appropriate. She did not, however, attribute the cause of her well-being to the mismatch between what she knew she should be providing and what she was able to provide. Instead, she referred to herself as a 'perfectionist', and shouldered the responsibility for her well-being.

Aligned to this tension was an apparent resistance to the notion that the responsibility for well-being rests solely with the practitioner: "*We are told to be 'more resilient' as if the stress of the job is somehow all the fault of the employee*" (ID96). The use of the words 'as if' carry an implication that it might not be the case that feeling stressed points to a failure in the individual. Possible characteristics of the job itself might contribute to stress; but go unacknowledged. In addition, 'fault' has negative connotations of culpability, alluding to a system that is unsupportive of its employees.

Various respondents acknowledged that some of their answers might have been influenced by factors external to their working lives – *"…life outside of work is… stressful*" (ID20). Some SLTs (*n*=19) remarked that personal circumstances contributed to stress. Stressors included life events/developments e.g., the recent bereavement of a close relative (ID261), experiencing the menopause (ID78), ill-health not related to work e.g.,

post-natal depression (ID345), bipolar disorder (ID530), other demands e.g., currently completing a PhD alongside clinical work (ID323), strains at home (ID273) and family 'issues' (ID422). Three self-employed SLTs felt that any stress they were experiencing was unconnected to their work, e.g., "…*stress is related to family illness and issues and none is work related*" (ID130) and "*negative answers refer not to my work*" (ID23).

2.2. Descriptions of self and a mismatch in ideals.

Some respondents made comments that related to how they viewed themselves. Statements revealed feelings of professionalism ("*I aim to do the best I can*", ID66), commitment ("*SLTs are 'highly driven' to help our clients*", ID184), confidence ("*I'm good at it…*" ID13), resilience ("*I am a very resilient person*", ID415) and pride in the job ("*I maintain a high professional standard. It's something I pride myself on*", ID110).

Changes to the way services are delivered may result in a mismatch between what SLTs regarded as the principles underlying their work, and those that the NHS now represented. One SLT commented "*My values are increasingly at odds with the organisations I work for*" (ID119). Another expanded:

> "*I joined the NHS in 1985 because I was proud of the ideals - and wanted to be part of it. Now - with the change in culture to a business rather than a public service - and the loss of respect for clinical services - I find that I am counting down to retirement (still 4 years away) - and that I don't want to be part of it anymore*." (ID32)

One participant described being unable to provide the input that she felt patients required. She stated, '*I do not really feel that I am a speech therapist any more…*' (ID258). This statement sheds some light on the effect on sense of professional identity that being prevented from practicing in the way that one expects can have.

3. **Theme 3: Occupational well-being.**

3.1. Loving the job.

Of the 128 SLTs who worked, or had worked for the NHS, 13 indicated that they enjoyed their jobs. Of these, only two made statements that were not followed by qualifying details: *"I really do enjoy my job and feel well supported"* (ID62) and *"I love my job. I love my job and not working would seriously affect my mental health"* (ID300).

Loving the job, however, is more complex than first glance would suggest, with 11 of the 13 respondents that stated that they loved or enjoyed their jobs qualifying their statements. One stated, "*In theory, I really love my job.*" (ID307). Her use of the qualifier 'in theory' suggests an abstract notion of a job that could be loved, but that the love exists on a hypothetical level, with a possible absence of circumstances that would foster that love in reality. Another respondent phrased this sentiment slightly differently. After a paragraph detailing staffing cuts, SLTs under pressure and unsupportive management she said: "*I love my profession, I just wish that I was allowed to do it.*" (ID258). She chose to focus on the love for the profession as a broader construct, with the implication, given her comments on the practicalities involved, that her actual job did not provide the context in for her love of the profession to be realised.

Some respondents used the past tense when describing their feelings *("…the work I most enjoyed…before the cuts occurred…*" (ID196) and "*I have loved being a SALT but am grateful to have had the career at the time I was able to be a therapist*" (ID166). Some used the words "but" or "however" and then went on to provide more detailed descriptions of their feelings or of elements of their jobs that they found to be unsatisfactory e.g. "*I love my job but do find it overwhelming and exhausting*" (ID390), "*I love my job…however the role is poorly understood by others and our team is under resourced*" (ID384).

There could be a number of reasons why SLTs begin with an affirmation, before going on to describe negative aspects of the job. The statements could be taken at face value – SLTs could really love their jobs but find aspects of the job difficult. It is also worth considering the culture that SLTs work within. One respondent stated that "…*sometimes I feel that I'm not 'allowed' to feel anything other than passionate and enthusiastic about my job.*" (ID115). This statement suggests that SLTs feel they do not have permission to

feel anything other than positive. Answers could therefore have been an initial, automatic response that reflects this culture, followed by more reflective comments.

Twenty respondents who were self-employed left comments about their feelings. They provided a contrast to the NHS employees and their responses have therefore been reported separately. Most viewed the decision to become self-employed as positive e.g. *"Best job in the world"* (ID129). Other terms that SLTs used to describe their feelings about their being self-employed included, *"happy"* (ID76), *"perfect and totally satisfying"* (ID6), and *"worthwhile"* (ID83).

Some compared working for themselves with being an employee, with respondents preferring self-employment over employment generally and over being employed in the NHS specifically. Respondents used comparative terms such as "*considerably happier and less stressed*" (ID176), and "*more fulfilling*" (ID453). One respondent reflected on her answers to the questionnaire: "*My responses would be very different (in a negative way) if I still worked in the NHS*" (ID162). Another described the improvement in her well-being:

> "*Since being made redundant from the NHS my health has improved. I now sleep, I'm happy and I don't feel bullied by managers. I set up my own business and it's the best decision I ever made…"* (ID76)

For some SLTs, becoming self-employed was not an obvious route to take. There was evidence of loyalty to the NHS, with one respondent describing resolving to leave as "*a very hard decision to make*," (ID224). Another expanded on this conflict:

> *"My quality of working and home life has improved dramatically since I became self-employed and this outweighs the feelings of guilt at having left the NHS, an institution I wholeheartedly believe in. I never wanted to work independently but it has changed my life, for the better." (ID151)*

3.2. Stress.

Of the 128 respondents who commented on the NHS, a number of respondents (n=45) mentioned 'stress' in their comments e.g., "*the emotional stress has had a significant effect on my life"* (ID65), "*GP supported 'stress' in part due to work*" (ID106), and "*lack of*

staffing causing me most stress" (ID37). Some SLTs explicitly linked the pressures of the job to stress:

> *"With constant funding cuts and reduced funding, yet higher demands in the hospital setting for getting patients out of hospital quickly, there is increased pressures on the SLT as a whole. This quickly leads to increased stress." (*ID415*)*

In addition to the term 'stress', some used other terms to describe their responses to work. One respondent stated that "*morale is very low*" (ID273), and another reported feeling "*burnt out*" (ID218). Comments pointed to a worsening of the situation over time with statements such as, "*working within the NHS feels like it is getting harder and harder and less rational and less compassionate*" (ID164), "*completing my job to a satisfactory level is increasingly difficult"* (ID125), and *"the stress of working (for) the NHS (is) increasingly hard to manage"* (ID19).

4. **Theme 4: The biopsychosocial consequences of stress.**

Responses included various biopsychosocial consequences of stress. These encompassed physical, psychological, social, and behavioural responses.

4.1. Physical consequences.

Very few SLTs mentioned the physical consequences of stress. However, there was mention of repetitive strain injury and voice problems (ID265), migraines (ID19) and long-term health issues *("I have been diagnosed with a life-long health condition... two years ago. It is likely to have been set off by stress from working for the NHS*", ID169). One respondent simply stated, "*I'm tired. Really tired."* (ID144) and did not elaborate – her comment could refer to being physically or mentally tired.

4.2. Psychological and social consequences.

Numerous negative feelings were reported, including guilt, failure, inadequacy (ID115, ID244), a lack of optimism (about the situation improving), frustration and disappointment (ID15, ID26, ID115, ID559). Other terms used to describe feelings were 'low',

‘overwhelming’, ‘disheartening’, ‘demotivating’, and ‘demoralising’ (ID94, ID248, ID257, ID340, ID441). The most frequently employed descriptor, however was ‘anxiety’ (n=11), with anxiety being described by one respondent as “*a chronic issue*” (ID57). Another SLT, working for a social enterprise affiliated to, and providing services for the NHS wrote:

> *“I cried at work today. The amount of work is over-whelming, I didn't want to come back after the weekend, and I’ve been looking for other jobs, and am considering leaving SLT as a career after nearly 26 years.” (ID96)*

The emotional burden on participants was also evident e.g., one SLT stated that she had a “*heavy emotional load*” at work and felt “*the effects of the work that (she did) emotionally*” (ID385). Some likened being able to do the job well to being engaged in battle (“*I feel like I have to fight for everything…*” ID164); this could mean that SLTs reached a point where they felt unable to carry on *(“I feel it is too much to continue”* ID19). There were descriptions of having had support for difficulties, with one SLT reporting that she had received support from both her GP and an NHS clinical psychologist for stress (ID106), and another stating that she was receiving “*treatment for depression currently*” (ID406).

One comment, by a respondent who was employed by an independent special school, gave a sense of the complexity inherent in the way psychological and social well-being is influenced by the combination of personal and work factors:

> *“Whilst I am happy in my job, I am not content in my personal life and find both often influence each other. I procrastinate all the time about most personal and professional activities and often don't want to leave my house once I get home. I feel this is because I need wind down time but also as I don't want to face or interact with groups of people once I've finished work. I don't have a lot of friends in the area and this also gets me down/contributes to me staying in in the evenings. I feel anxious about my personal life most of the time and this has a moderate influence on my mood at work although I tend to mask it by acting upbeat, which in itself is tiring. I do not feel depressed but certainly anxious and possibly over conscientious, hence working over-time. I do exercise 3 or 4 times a week which I feel is beneficial mentally and physically. However, I have come to the conclusion that seeking professional counselling/psychological advice would be beneficial for my personal mental*

health and well-being. This is something I am currently looking in to. I love being a SALT and being part of the SALT community e.g. CENS, colleague discussions. I feel I need to figure out the work/life balance a bit better though in order to make (sic) more productive with my time" (ID269).

The SLT who provided this statement commented on her feelings about her personal life and her work, how these domains influence one another, how she attempted to look after her well-being (through exercising) and what she would do to address what she viewed as problematic. She was explicit regarding the concerns she had about her life outside work, stating she was 'not content' and was 'anxious' about her personal life. This contrasted with her statements regarding work – initially she asserted that she was 'happy' at work, and later she said, "*I love being a SALT*". There is evidence, however, that work may have influenced her home life, affecting her ability to engage socially in her community. She stated that she worked overtime (although she attributed this to being anxious and '*possibly over conscientious'*). She also reported that she didn't want to leave the house once she got home; and felt the reason for this was that she needed to '*wind down'* and that she didn't want to '*face or interact with groups of people*' once she had finished work. The use of the phrase 'wind down' implies that work left her feeling anxious or strained. The reasons for her anxiety therefore appear to be more complex than at first reading. Work was possibly partially responsible for her anxiety, with the nature of work resulting in her not wanting to go out, possibly contributing to her worrying about her personal life. At the end of the statement, she indicated that work may be contributing to her difficulties, by saying that she needed to 'figure out the work/life balance'.

4.3. Behavioural consequences.

Behaviourally, the main response to stress was absenteeism. Some respondents mentioned the length of time that they had been off work due to stress, and this ranged from one to six months (ID11, ID91, ID320). Others did not specify the length of time that they had been off but described having had time off "*due to work pressures"* (ID567), "*long term sick (leave) due to work related stress and anxiety*" (ID178) and being "*off work for a long period due to stress*" (ID57). One respondent mentioned working for three weeks "*whilst unwell*" (ID320), prior to being signed off. Another stated that she '*went back to work too early before I was fully recovered. However, knowing that everything I was cancelling while off work would need rebooking into an already full diary did not make it*

easy to rest and recover". (ID112) These comments suggest they had both engaged in presenteeism.

Some (n=10) responded to increasingly stressful environments by resigning from their jobs. Several became self-employed. One SLT maintained that she had left the NHS due to the "*appalling*" conditions and "*minimum support"* within an acute hospital trust where she had worked (ID490). Other NHS SLTs (n=4) had handed in their notice at the time of the survey. One stated, "*I am reluctantly handing in my notice for my NHS job this month after being in the profession for 35 years as I feel it is too much to continue to provide a good level of service to clients and look after my health."* (ID19), For those who had become self-employed, leaving organizational employment had resulted in an improvement in "*quality of working and home life*" (ID151) and an improvement in health (ID76).

Appendix E1

Interviewee profiles

SLTs Who Are Employed (n=10)

Alice

Alice was an SLT who qualified in 1999. She was married and had two children living at home. Alice worked with adults, when she completed the survey she was off work with stress and by the time she was interviewed, she had recently left the NHS and was planning to begin working as an independent SLT. When she completed the survey, Alice had been working part time in the NHS, in an IsoStrain job. She reached caseness on the GHQ-18 (binary score=19). In addition, she had very low job satisfaction, and moderate to severe stress on the SLPSI (raw score=3.9). Alice was very committed to the service-users with which she worked, stating, "I love my patients". She also described working with patients who had Motor Neurone Disease as "heavy", alluding to the burden that working with those who have a degenerative disease can have. She spoke about feeling exhausted and having to take work home. Alice's sense of value was affected by being told, during service restructuring, that she should think herself "lucky (she'd) been paid at that level for that long because she probably didn't deserve it anyway…"

Anne

Anne was a paediatric SLT, who worked part-time (4 days per week) in the NHS. She was single and lived alone. Her initial interest was in psychology, but after investigation into the career, she decided not to pursue it. During the course of her research, she discovered speech and language therapy, which she thought would be interesting. She took a gap year after completing her A levels, and then studied at a Russell Group university, where she came top of her class, graduating in 1994. Anne always felt ambivalent about being an SLT, describing how after graduating, she didn't really want to get a job as an SLT. She has had two career breaks but found that other jobs seemed to 'lead her back' to SLT, although she also related how she found coming back to the profession hard each time. Anne described herself as 'not like her colleagues', stating that she felt quite isolated in her department. She became distressed when talking about how she felt she couldn't

do the job to the standard that she wished to. While stating that others seemed to be satisfied working as SLTs, she also felt that everyone working in the NHS was stressed. Anne felt that the work she was doing was futile, as her comments demonstrate: "…stuff we're doing, I can't necessarily see that it's working…" and "…what's the blimming point…?" She had an IsoStrain job and reached caseness on the GHQ-28. She had low job satisfaction, and moderate to severe stress on the SLPSI (3.35).

Carol

Carol qualified in 1991. She was divorced and did not have children living at home. When filling in the survey, she had an Active Collective job and high job satisfaction. However, she had moderate to severe stress on the SLPSI and achieved caseness on the GHQ-28 (binary score=17). When she filled in the survey, she stated that she was planning to leave her job. By the time she was interviewed, Carol had left the NHS, where she had been working full-time as a paediatric SLT. She had also left the career. While Carol felt responsible for the service-users with whom she worked: "I couldn't walk away from her, as a woman who was vulnerable," she was also discouraged by the lack of prioritization of SLT services within a trust: "It is demoralizing, isn't it?"

Gwenneth

Gwenneth worked full-time in the NHS, as a paediatric SLT, and had done since qualifying in 1989. She was divorced and did not have any children living at home. When completing the survey, she stated that she was considering a career change. Gwenneth had an Active Collective job and high job satisfaction. However, she achieved caseness on the GHQ-28 (binary score=7). Gwenneth spoke about the effect that the mispatch between capacity and demand had on her, "…you spread yourself too thinly…". As a team leader she was aware of the necessity to support her colleagues and initiated informal support sessions, which she called 'Offload' sessions.

Hendre

Hendre was an SLT who worked with adults. She qualified in 1981. Hendre was married and had one child living at home. She was employed part-time (three days a week) in the NHS. She had a High Strain Collective job and achieved caseness on the GHG (binary

score =15). She had average job satisfaction and moderate to severe stress on the SLPSI. Hendre's focus during the interview was how her treatment by a specific manager had severely impacted on her mental health and had resulted in her having stress leave and moving from full time to part time. She commented on capacity/demand, stating that "We're the Marmite Service. We're spread so thinly."

Jan

Jan was employed full-time in the NHS, having qualified in 2016. She worked with adults. Jan lived with her partner and had no children living at home. She had an Active Collective job and average job satisfaction. She had mild to moderate stress, but she achieved caseness on the GHQ-28 (binary score=13). In many ways, Jan contrasted the other participants – she felt that she was well supported. She enjoyed her job and felt proud to work in the NHS but acknowledged that, as a Band 5 SLT, she was 'protected' by her Band 6 colleague. However, her job was not without stressful events and she also spoke about a heavy workload, and how targets created worry: "…that kind of plays on my mind". In addition, for her, the emotional repercussions of working with patients who are "really poorly" was an issue, which she felt needed more acknowledgement in the profession. Finally, she felt that the profession was not understood.

Jo

Jo was an SLT working with adults. She had qualified in 2005, was married, and had one child living at home. When she completed the survey, she was employed part-time (three days a week) by a charity but had handed in her notice as she felt her job was 'high demand, low support'. By the time she was interviewed, she had secured a new job in the NHS, working four days a week. Her narrative revealed that in her new job there were continuing difficulties with obtaining supervision, that staffing levels were poor and that the workload was unmanageable. Jo's initial job, when she completed the survey, had been an Isostrain job, and she achieved caseness on the GHQ-28 (binary score=6). She had average job satisfaction (raw score=32), and moderate to severe stress on the SLPSI while in that job. The interview with Jo revealed that, while she loved the 'essence' of the job, her new job continued to cause her stress. She felt responsible for the patients with whom she worked, "It's very compelling to try and do more for your patients, isn't it?" but

struggled with the workload, "…we were all on our knees…" and did not receive supervision.

Kathryn

Kathryn was employed part-time (four days a week) by a social enterprise that provided services to the NHS. She had qualified in 1992 and was married with one child living at home. She felt that her job did not differ very much from when she had been employed by the NHS. Kathryn had an IsoStrain job and achieved caseness on the GHQ-28 (binary score=12). She had very low job satisfaction and moderate to severe stress on the SLPSI. Kathryn spoke about the responsibility to service-users as being a "huge burden" and felt unsupported in her job, sharing how there had been a period at work where she'd cried every day but how her feelings had been dismissed, "Oh, don't worry, you're about the 10th person that's cried…". She also felt that it was a 'battle' to justify her profession. Kathryn was aware of how resilience was currently a widely discussed topic but felt that it was poorly understood.

Pamela

Pamela qualified in 1987. She worked full-time in the NHS, was married and did not have children living at home. She worked with adults with learning difficulties. When she completed the survey, she had recently returned to work, having had time off for stress. Pamela worked in a High Strain Collective job. She had average job satisfaction (raw score=32), moderate to severe stress, and she achieved caseness on the GHQ-28 (binary score=23). Pamela shared how she had had numerous times off work with stress over her career. Her account was unique in its description of her relationship with the NHS as abusive – that the NHS 'beats you hard' and that she was 'grateful to the NHS' and 'very lucky' that she was supported when off on stress leave.

Susan

Susan worked as a full time paediatric SLT in the NHS. She qualified in 2014. When completing the survey, Susan stated that she had a partner, with whom she was not living. At the time of the second survey, she was single. She had no children living at home. Susan had a High Strain Collective job. She achieved caseness on the GHQ-28 (binary

score=22) and had moderate to severe stress. Her job satisfaction was average. Susan felt that the lack of control she had over clinical decisions resulted in her experiencing cognitive dissonance, she also appeared to experience conflict about her job, she described it as ‘unbearable’ but also said that she ‘loved’ it. Susan felt well supported in by her fellow team members. Susan described having ‘mini burnouts’ throughout her working life.

Self-employed SLTS (n=5)

Ruby

Ruby qualified in 1993 and had worked for the NHS for the majority of her career. She was married, with two children living at home. When completing the survey, she was working as a sole trader. Ruby was as a paediatric SLT, employed directly by families. She worked six days a week. Most of her work was during term time, with a small amount during school the holidays. Ruby had an Active Collective job and did not achieve caseness on the GHQ-28 (binary score=3). She had low job satisfaction and mild to moderate stress on the SLSPI. Ruby had left the NHS to become self-employed after she was directed – by a manager with no understanding of speech and language therapy - to work with a vulnerable client-group with whom she had no experience. She felt that, while she worked hard to ensure that she was able to provide a quality service, the decision had placed her in a vulnerable position, which she was not willing to experience again. Ruby enjoyed working independently experiencing a good level of control and support. The stress that she felt as an independent SLT came from the imbalance of workload between term time (when she was very busy) and school holidays (when she had little work). This imbalance had financial implications for her. Ruby described having ‘micro-frustrations’ during her working days.

Lesley

Lesley was a paediatric SLT, she qualified in 1993. She was married, with two children living at home. She was a sole trader, employed directly by families. Although on the survey she stated that she worked four days a week, when interviewed, her caseload had expanded, and she was working full time. Most of her work was during term time, with a small amount in the school holidays. Lesley had a Low Strain Collective job, and her job

satisfaction was very high. She had mild stress on the SLPSI and did not achieve caseness on the GHQ-28 (binary score=0). Lesley had worked as a locum for the NHS before becoming self-employed. She emphasised how having control over her work was one of the things that she enjoyed most about working independently. Lesley felt responsible to the schools in which she provided a service, which could lead to her accepting referrals that increased her workload to unmanageable levels. Ones of her values – that speech and language therapy should be accessible to all, regardless of financial status - was compromised when people had to pay for her services, “I actually struggle with the fact that I charge people for my services.”

Sally

Sally qualified in 1999. She was married, with two children living at home. She had worked in the NHS before becoming self-employed. She worked four days a week as a paediatric SLT – partly for herself, as a sole trader; and she was partly employed by and independent practice. When Sally completed the survey, she had stated that she was self-employed, working as a sole practitioner, and she answered questions for one job. She had an Active Isolated job, and low job satisfaction. However, she did not achieve caseness on the GHQ-28 (binary score=3) and had moderate to severe stress on the SLPSI. Sally found the career fulfilling, her values included being of service, and speech and language therapy being accessible to all, regardless of financial status. The first of these was compromised when working in the NHS and being unable to affect change due to service constraints, the second was jeopardized when she started working independently. However, she felt better about charging for her services when she considered that her clients were able to benefit from what she was providing, which felt different to the NHS.

Isabella

Isabella qualified in 2008. She was single and had no children living at home. Isabella worked full time as a paediatric SLT. She was an independent SLT, who contracted to a private company that provided services into schools. She had an Active Collective job and very high job satisfaction. However, she had moderate to severe stress on the SLPSI and achieved caseness on the GHQ-28 (binary score=5). Isabella felt that working independently carried similar stresses to working for the NHS. She provided a service for a company that had contracts with schools, and Isabella felt that it was her responsibility

to work with all the children who were referred within a given school – at times this was not manageable, given time constraints. Isabella would have liked to work fewer hours but as a single person felt that the financial demands she had prevented her from doing so. This also meant that when she was ill, she was unable to take time off work.

Willow

Willow worked as a sole trader, with adult clients who employed her directly. She qualified in 1997, was married, and had two children living at home. Willow had a Low Strain Collective job, and very high job satisfaction. She had mild stress and did not achieve caseness on the GHQ-28 (binary score=0). Willow loved what she did. She experienced conflict around leaving the NHS but justified doing so by taking her patients' views (who wanted more therapy) into account. Working independently, she justified charging for her services by engaging in activities to support the profession, "I do a lot of free work." Willow felt very supported in her current role, and had the authority to manage her work demands, her phrase, "I'm driving my own boat" described this well.