ISSN 2055-0286
Advances in Social Sciences Research Journal; Vol. 13 No. 03 (2026) (281-290)
https://doi.org/10.14738/assrj.1303.20171

Work Engagement in a Transforming Mental Health Care System: A Longitudinal Study Among Healthcare Professionals

Eileen Staring[1], Lars de Vroege[2], Anneloes van den Broek[1, 3, *]

1. GGz Breburg, Breda, The Netherlands
2. Aelbrecht GGZ, Waalre, The Netherlands
3. Tranzo, Scientific Center for Care and Wellbeing, Tilburg University, Tilburg, The Netherlands

Abstract: Mental healthcare systems are increasingly challenged to ensure accessibility, quality, and continuity of care. In response, a Mental Healthcare Institution in the south of the Netherlands, GGz Breburg implemented a large-scale organizational transition. To meet the increasing demand for care with scarce capacity and to keep mental health care available for care recipients who need specialized treatment. During the transition, small-scale transdiagnostic mental healthcare centers (MHC) were set up, closer to care recipients. In addition to MHCs, expertise centers (ECs) of GGz Breburg, intended for more specialized, complex, and/or longer-lasting treatments, continue to exist. The work environment of the healthcare professionals was reorganized into MHCs or ECs, or a combination of both. This study examined the effects of this transformation on work engagement and work experience among these healthcare professionals. A prospective longitudinal design was applied, with measurements at three time points between 2023 and 2025. A total of 733 participants completed the Utrecht Work Engagement Scale and the Groningen Work Experience Questionnaire. Results indicated that work engagement and most aspects of work experience remained stable over time. A small but statistically significant improvement was observed in perceived contact with supervisors. No significant changes were found in workload or absenteeism. These findings suggest that large-scale organizational change in mental healthcare does not necessarily negatively affect employee well-being. The results underline the importance of leadership, social support, and psychosocial resources in sustaining work engagement during periods of change.

Keywords: mental healthcare, work engagement, organizational change, work experience, healthcare professionals, workload.

INTRODUCTION

Mental health care is currently subject to considerable strain. Prevailing conceptualizations of health, together with the organizational configuration of the existing mental health care system, necessitates substantive reform. The demand for mental health services continues to increase, caused by demographic developments such as population growth and aging, rising levels of prosperity, and broader societal transformations [1]. Contemporary society is characterized by increasing complexity, including heightened performance pressures, economic insecurity, and an ongoing process of medicalization [2]. In 2023, 97,450 individuals were on waiting lists for mental health care, rising to 108,878 in 2024 [3]. In response to these developments, numerous organizations have endorsed the Integrated Care Agreement [4], which aims, inter alia, to stimulate the expansion of primary care services

and to strengthen the social domain. Furthermore, the agreement promotes the decentralization of care delivery to community-based settings and seeks to mitigate escalating healthcare expenditures [5].

In alignment with this agreement, several Dutch mental health care institutions have initiated structural transformations. To ensure that mental health care remains accessible, of high quality, and financially sustainable by 2025, the mental healthcare institution GGz Breburg has implemented an innovative model of care delivery. Mental Health Centers (MHCs) have been established, facilitating collaboration between primary and specialized mental health services within a community-oriented network structure aimed at enhancing mental well-being [6]. These centers primarily focus on the provision of short-term interventions and the prevention of unnecessary referrals to specialized services. Preliminary findings indicate that approximately 25% of individuals seeking support did not require entry into specialized mental health care [7], thereby contributing to the alleviation of waiting lists. In parallel, Expertise Centers (ECs) remain operational, specializing in complex care demands, rare conditions, and intensive treatment modalities, while also providing consultation and facilitating knowledge exchange among mental health professionals. Although the initial outcomes of this transformation appear promising and suggest improvements in the quality of care, it is unclear what this change means for the healthcare professional.

Employment within the mental health care sector is widely recognized as demanding, complex, and emotionally draining, as reflected in the relatively high rates of absenteeism observed within this domain. According to Dutch Statistics [8], the national average absenteeism rate across all sectors is 5.8%, whereas absenteeism within healthcare is substantially higher. Specifically, absenteeism within mental health care was reported at 7.7% in 2024, increasing further to 8.3% in the first quarter of 2025.

Healthcare professionals are at an elevated risk of developing mental health problems and experiencing burnout-related symptomatology [9, 10, 11, 12,13]. One explanation for this is that the healthcare professional primarily works in a field with a one-way relationship in which the care provider cares and the client receive. The establishment and maintenance of such one-way relationships require substantial emotional and cognitive investment [14]. Consequently, healthcare professionals must possess and continually apply specific competencies to safeguard their own well-being within a work environment that prioritizes the needs of others. It is therefore unsurprising that symptoms of depression, anxiety, stress, and trauma-related disorders are prevalent among care providers [15, 16, 17, 18]. Moreover, there is also an increased risk of developing secondary trauma-related complaints [19, 20].

In recent years, a growing proportion of healthcare professionals have exited the sector [21], or have contemplated doing so, partly due to the heightened workload experienced during and after the COVID-19 pandemic [22]. Annual turnover rates are estimated to range between 10% and 15% [2], with nearly half of departing employees leaving within the first two years of employment. Workforce shortages are projected to intensify [23], resulting in prolonged waiting times for clients and a concomitant increase in workload for the remaining workforce. The increasing pressure on mental health care systems places substantial demands on the mental well-being, engagement, and motivation of healthcare professionals [24].

Prior research has demonstrated that high levels of work engagement are associated with increased job satisfaction, enhanced job performance and quality of care, reduced stress levels, and lower turnover intentions [25, 26, 27. Work engagement is characterized by elevated levels of energy and a strong identification of one's work. Highly engaged employees perceive their work as meaningful and intrinsically motivating, experience a strong sense of connection to their professional role, and exhibit enthusiasm and pride in both individual and organizational achievements, thereby contributing to overall job satisfaction [28]. Furthermore, job resources such as social support from colleagues and supervisors, performance feedback, task variety, and opportunities for professional development have been shown to be positively associated with work engagement [25]. Schaufeli and Bakker [29] define work engagement as a work-related, positive, and fulfilling state of mind, characterized by three core dimensions: vigor (high levels of mental resilience and energy), dedication (a strong sense of significance, enthusiasm, and involvement) and absorption (full concentration and deep immersion in work activities).

Work experience, as conceptualized by Heijnen [30], constitutes a broad and multidimensional construct encompassing both work-related factors such as job content, social interactions, and physical and psychosocial working conditions and individual characteristics, including cognitive, motivational, and relational attributes. The dynamic interaction between these contextual and personal factors largely determines how work is perceived and experienced. Prolonged dissatisfaction with one or more of these components may result in adverse outcomes, including diminished well-being, reduced motivation, and decreased productivity. Conversely, positive work experience is associated with improved functioning and sustainable employability [30].

While the necessity for reform within mental health care is unequivocal, its implications for employees' work experience remain insufficiently understood. In a sector characterized by elevated levels of absenteeism and staff turnover, fostering work engagement is of critical importance. It is anticipated that the systemic transformations will alleviate pressure on the healthcare system, thereby exerting a positive influence on both work engagement and work experience among healthcare professionals. Consequently, a reduction in absenteeism rates may be expected. The present study aims to examine the impact of these transformations within mental health care on the work engagement of healthcare professionals.

METHODS

Participants

All healthcare professionals employed at the mental healthcare institution GGz Breburg between 2023 and 2025 (N = 1040) were invited to participate by email. The sample included psychiatrists, psychologists, nurses, nurse practitioners, and other professionals such as art therapists and case managers. Participants worked in MHCs, ECs, or both settings. Inclusion criteria were employment within these centers and provision of informed consent.

Measures

Two standardized questionnaires were administered: the Utrecht Work Engagement Scale (UBES) and the Groningen Work Experience List (GWL).

Work Engagement (UBES)

Work engagement was measured using the Utrecht Work Engagement Scale (UBES) designed by Schaufeli (2003), consisting of 17 items divided into three subscales: vigor, dedication, and absorption. Examples of the vitality scale are: 'at my work I am bursting with energy', for dedication: 'my work inspires me' and for absorption: 'my work captivates me'. Items were scored on a 7-point Likert scale (0–6), with higher scores indicating higher engagement. The internal consistency is high for both the individual scales and the entire questionnaire (α: vitality= 0.84, dedication= 0.89, and absorption= 0.79).

Work Experience (GWL)

Work experience (GWL; Heinen, 2014) was measured with 10 items that encompass different dimensions of work experience, including physical and psychological stress, workload, work atmosphere, contacts with colleagues and supervisors, the meaningfulness and enjoyment of work, as well as absenteeism. Items were scored on a 4-point scale, with higher scores reflecting less favorable work experience. The internal consistency of the GWL is α = 0.66.

Procedure and Design

Data was collected digitally using Qualtrics [31] three times between 2023 and 2025, with approximately nine months between measurements. The study employed a prospective longitudinal design, allowing for the analysis of changes over time. Ethical approval was obtained from the institutional review board of GGz Breburg.

Statistical Analysis

Descriptive statistics were used to summarize demographic characteristics. Repeated measures ANOVA and independent t-tests were conducted to evaluate changes in work engagement and work experience over time. Analyses were performed using SPSS version 29 [32].

RESULTS

The results of this study on work engagement and work experience of healthcare professionals at GGz Breburg are presented below. After an overview of the sample, the outcomes of the individual questionnaires are discussed. Finally, the testing of the pre-formulated hypotheses regarding the effects of the changed working method on work engagement and work experience is addressed.

Sample Characteristics

A total of 893 participants completed the questionnaires. After excluding incomplete responses, the final sample consisted of 733 participants. The majority of participants were female (79.8%), with ages ranging from 20 to 70 years. Most participants were psychologists, and the majority of health care professionals worked in Expertise Centers (76.3%). The demographic characteristics are presented in Table 1.

Table 1: Demographic Characteristics

Variable	Category	T1	T2	T3
		N (%)	N (%)	N (%)
Gender	Female	218 (79.9)	185 (81.5)	169 (77.9)
	Male	55 (20.1)	42 (18.5)	48 (22.1)
Profession	Psychologist	90 (32.4)	94 (41.0)	65 (29.0)
	Nurse	68 (24.5)	33 (14.4)	43 (19.2)
	Nurse practitioner	13 (4.7)	19 (8.3)	25 (11.2)
	Psychiatrist	10 (3.6)	14 (6.1)	16 (7.1)
	Other	85 (30.6)	57 (24.9)	51 (22.8)
Workplace	Expertise Center (EC)	208 (79.4)	157 (73.4)	156 (75.4)
	Mental Health Centre (MHC)	39 (14.9)	32 (15.0)	40 (19.3)
	Both EC & MHC	15 (5.7)	25 (11.7)	11 (5.3)

* Abbreviations: EC, Expertise Center; MG, Mental Health Centers

Work Engagement

Work engagement remained stable across all time points. Dedication consistently scored highest, followed by vigor and absorption. A small significant difference was found for vigor between T1 and T2, but effect sizes were small. The comparisons of work engagement between measurement moments for the UBES are presented in table 2.

Table 2: Comparisons of work engagement between measurement moments for the UBES.

Subscale	T1 vs T2	T2 vs T3	T1 vs T3
Vigor	*p = 0.014; d = 0.20; 95%-CI [0.02–0.37]	p = 0.061; d = –0.15; 95%-CI [-0.33–0.04]	p = 0.276; d = 0.05; 95%-CI [-0.12–0.23]
Absorption	p = 0.183; d = 0.12; 95%-CI [–0.06–0.30]	p = 0.233; d = –0.07; 95%-CI [-0.25–0.12]	p = 0.289; d = 0.05; 95%-CI [-0.13–0.23]
Dedication	p = 0.063; d = 0.17; 95%-CI [–0.01–0.34]	p = 0.375; d = –0.03; 95%-CI [-0.21–0.15]	p = 0.064; d = 0.14; 95%-CI [-0.04–0.31]

*Significant difference p < .05; d = Cohen's d; CI = confidence interval

Work Experience

Most aspects of work experience remained stable. A small improvement was observed in contact with supervisors. The average scores on the GWL are presented in table 3.

Table 3: Average scores (M ± SD) on the GWL over three measurement points.

Subscale	T1	T2	T3
Physical load	1.73±0.83	1.74±0.82	1.80±0.85
Psychological load	2.91±0.81	2.99±0.74	2.92±0.76
Work pressure	2.64±0.74	2.78±0.71	2.75±0.68
Work atmosphere	1.56±0.73	1.70±0.79	1.55±0.73
Colleague contact	1.28±0.52	1.26±0.52	1.27±0.56

Supervisor contact *	1.69±0.84	1.74±0.85	1.56±0.75
Meaningfulness	1.33±0.57	1.31±0.52	1.36±0.59
Work experience	1.82±0.61	1.88±0.63	1.87±0.58
Absenteeism (past)	1.49±0.74	1.46±0.71	1.46±0.69
Absenteeism (expected	1.27±0.56	1.36±0.59	1.29±0.57

* Higher scores indicate less favorable work experience or higher workload.

$p < 0.05$ indicates a *significant difference between measurement points (GWL 6: Contacts with supervisors).

Description of the Hypotheses

The study was based on the hypothesis that the introduction of a new way of working (working in an MHG or EC) among healthcare professionals would lead to higher work engagement and more positive work experience, combined with a reduction in perceived workload and absenteeism. The results show that for most aspects of work experience and workload, no significant changes were observed across the measurement moments. This applies to physical and psychological workload, work pressure, work atmosphere, contacts with colleagues, overall work experience, and expectations regarding absenteeism. An exception was found in the subscale “contacts with supervisor(s)” of the GWL, where a small but significant difference was observed.

Both the UBES and GWL results indicated that perceived work pressure remained approximately the same across the three time points. Absenteeism in the past year and expected absenteeism in the next 12 months did not change significantly across the measurement moments.

DISCUSSION

This study examined the effects of a change in working practices within GGz Breburg specifically, the implementation of working in an MHG and/or EC on healthcare professionals’ work engagement, work experience, workload, and absenteeism. The results indicate that, at the group level, work engagement and work experience remained largely stable across the three measurement points. Scores on the Utrecht Work Engagement Scale (UBES) were high, particularly for dedication, suggesting a strong level of involvement in work. A ceiling effect may have been present, as work engagement was already high at baseline, thereby limiting the potential for further increases (Table 2). On the Groningen Work Experience Questionnaire (GWL), most dimensions remained unchanged. Only perceived contact with supervisors showed a slight improvement, suggesting that managerial support may positively influence work experience. Absenteeism both in the past year and expected absenteeism remained stable, indicating that the organizational change did not have a direct impact on absenteeism. This stability can be interpreted in two ways. On the one hand, the findings suggest that structural challenges within mental healthcare, such as high workload and emotional demands, are not easily mitigated through organizational restructuring alone. On the other hand, the results indicate that these changes did not exacerbate perceived workload, which may be considered a positive outcome in the context of increasing care demands and staff shortages. Previous studies have shown that organizational resources, such as strategic alignment and engaged leadership, are associated with higher levels of engagement and motivation during periods

of change [33]. Social support [34], as well as autonomy and participation, are likewise related to higher work engagement and improved well-being among healthcare professionals [35, 28]. The slight improvement in contact with supervisors observed in this study is consistent with these findings and underscores the importance of supportive leadership. Although the hypothesis of a clear improvement was not confirmed, the absence of negative effects during a period of substantial organizational change is noteworthy. Previous research has demonstrated that transitions in mental healthcare are often accompanied by increased workload, uncertainty, and a decline in engagement [24, 25]. Against this backdrop, it is encouraging that work engagement did not decrease.

STRENGTHS AND LIMITATIONS

A notable strength of this study is its longitudinal design, which allowed the examination of changes over time. The relatively large sample size and inclusion of multiple professional groups enhance the reliability and relevance of the findings. Furthermore, the use of validated instruments ensures that work engagement and work experience were measured reliably and consistently. Despite these strengths, several limitations should be considered. First, the same respondents were not followed over time, meaning individual changes were not visible, which limits the ability to draw conclusions about individual level changes. Instead, the analysis reflects group level trends. Second, the reliance on self-report measures introduces the possibility of response bias, including social desirability.

Third, the study was conducted within a single organization, which may limit the generalizability of the findings to other settings or healthcare systems. Finally, selective participation may have influenced the results. It is possible that professionals with higher levels of engagement were more likely to participate, leading to an overestimation of engagement levels.

IMPLICATIONS FOR PRACTICE

The findings have important implications for healthcare organizations undergoing transformation. The stability of work engagement suggests that large-scale organizational changes do not necessarily harm employee well-being, provided that adequate support structures are in place. However, the lack of improvement in workload and absenteeism indicates that structural changes alone are insufficient to address these persistent challenges. Organizations should therefore complement structural reforms with targeted interventions aimed at reducing workload and supporting employee well-being. The improvement in supervisor relationships highlights the importance of leadership. Investing in leadership development, fostering open communication, and promoting a supportive work environment can play a crucial role in maintaining engagement during periods of change.

FUTURE RESEARCH

Future research should build on these findings by adopting designs that track individual participants over time, allowing for a more detailed understanding of how organizational change affects different employees. In addition, qualitative studies could provide deeper insights into how healthcare professionals experience organizational transformation and

which factors contribute most to their well-being. Further research could also explore the impact of specific leadership styles, team dynamics, and organizational interventions on work engagement and work experience. Lastly, comparative studies across multiple organizations would help to determine whether the observed patterns are consistent across different contexts.

CONCLUSION

This study demonstrates that, in the context of a transforming mental healthcare system, work engagement and work experience among healthcare professionals can remain stable over time. While the anticipated improvements were not observed, the absence of negative effects is itself a meaningful finding. In a sector characterized by high demand, workforce shortages, and increasing complexity, maintaining employee engagement is essential.

The results underscore the importance of supportive leadership and psychosocial resources in sustaining this engagement. Ultimately, the findings suggest that successful organizational transformation in mental healthcare depends not only on structural changes, but also on continued investment in the people who deliver care.

REFERENCES

[1]. KPMG. (2020a). Healthcare reimagined: Trends, voorspellingen en actiepunten om koploper in de zorg te zijn. Healthcare Reimagined - KPMG Nederland

[2]. Trimbos-instituut. (2023). GGZ uit de knel: Verkenning van mogelijkheden en valkuilen van het actuele hervormingsnarratief. https://www.trimbos.nl/aanbod/webwinkel/af2059-ggz-uit-de-knel

[3]. Nederlandse Zorgautoriteit. (2024). Informatiekaart wachttijden en wachtplekken ggz – oktober 2024. https://puc.overheid.nl/nza/doc/PUC_786033_22/

[4]. Rijksoverheid. (2022). Integraal zorgakkoord: 'Samen werken aan gezonde zorg'. Https://www.rijksoverheid.nl/documenten/rapporten/2022/09/16/integraal-zorgakkoord-samen-werken-aan-gezonde-zorg.

[5]. Trimbos-instituut. (2023). Hervorming van de ggz. https://www.trimbos.nl/kennis/hervorming-ggz

[6]. Van den Broek, A., De Vroege, L., Metz, M., Gribling, G., & Van Eerd, J. (2022). Aanpassing aan veranderende zorgbehoefte in de ggz: Mentale gezondheidscentra. Tijdschrift voor Psychiatrie, 64(1), 45–52.

[7]. Hoekstra, A. M., Buurman, E. P. M., Mahieu, E., van den Broek, A., Gribling, G., Bongers, I. M. B., Heijne, L., Verhaeren, M., & Metz, M. J. (2024). Het verkennend gesprek: Actieonderzoek naar het perspectief van zorgvragers. Tijdschrift voor Psychiatrie, 66(9), 508–515.

[8]. Centraal Bureau voor de Statistiek. (2025). Ziekteverzuim neemt toe in eerste kwartaal 2025. https://www.cbs.nl/nl-nl/nieuws/2025/24/ziekteverzuim-neemt-toe-in-eerste-kwartaal-2025.

[9]. d'Ettorre, G., Pellicani, V., & Ceccarelli, G. (2020). Post-traumatic stress disorder symptoms in healthcare workers: A ten-year systematic review. Acta Biomedica Atenei Parmensis, 91(12-S), e2020009. Https://doi.org/10.23750/abm.v91i12-S.9459.

[10]. Kunzler, A. M., Helmreich, I., Chmitorz, A., König, J., Binder, H., Wessa, M., & Lieb, K. (2020). Psychological interventions to foster resilience in healthcare professionals. Cochrane Database of Systematic Reviews, 2020(7), Article CD012527.

[11]. McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause of burnout among applied psychologists: A systematic review. Frontiers in Psychology, 9, Article 1897. https://doi.org/10.3389/fpsyg.2018.01897.

[12]. Nikunlaakso, R., Selander, K., Oksanen, T., & Laitinen, J. (2022). Interventions to reduce the risk of mental health problems in health and social care workplaces: A scoping review. Journal of Psychiatric Research, 152, 57–69. https://doi.org/10.1016/j.jpsychires.2022.06.004.

[13] Williams, A. M., Reed, B., Self, M. M., Robiner, W. N., & Ward, W. L. (2020). Psychologists' practices, stressors, and wellness in academic health centers. Journal of Clinical Psychology in Medical Settings, 27(4), 818–829. https://doi.org/10.1007/s10880-019-09678-4.

[14] Skovholt, T. M., & Trotter-Mathison, M. (2014). Resilient practitioner: Burnout prevention and self-care for counselors, therapists, teachers, and health professionals. Routledge.

[15] Riethof, N., Bob, P., Laker, M., Varakova, K., Jiraskova, T., & Raboch, J. (2019). Burnout syndrome, mental splitting, and depression in female health care professionals. Medical Science Monitor: International Medical Journal of Experimental and Clinical Research, 25, 5237–5240. https://doi.org/10.12659/MSM.915360.

[16]. van Hoy, A., & Rzeszutek, M. (2022). Burnout and psychological wellbeing among psychotherapists: A systematic review. Frontiers in Psychology, 13, 928191. https://doi.org/10.3389/fpsyg.2022.928191.

[17]. Schaffler, Y., Probst, T., Pieh, C., Haid, B., & Humer, E. (2024). Prevalence of mental health symptoms and potential risk factors among Austrian psychotherapists. Scientific Reports, 14(1), 3888. https://doi.org/10.1038/s41598-024-54372-7.

[18]. Riethof, N., & Bob, P. (2024). Traumatic stress symptoms, mental splitting and burnout in health care professionals: A cross-sectional study. Frontiers in Psychiatry, 15, 1332900. https://doi.org/10.3389/fpsyt.2024.1332900.

[19]. Henderson, A., Jewell, T., Huang, X., & Simpson, A. (2025). Personal trauma history and secondary traumatic stress in mental health professionals: A systematic review. Journal of Psychiatric and Mental Health Nursing, 32(1), 13–30. Https://doi.org/10.1111/jpm.13082.

[20]. Cocker, F., & Joss, N. (2016). Compasion fatigue among healthcare, emergency and community service workers: A systematic review. International Journal of Environmental Research and Public Health, 13(6), 618. https://doi.org/10.3390/ijerph13060618.

[21]. Stichting IZZ. (2022). Monitor Gezond Werken in de Zorg 2022. https://izz.nl/inzicht-onderzoek/inzichten/zorgmedewerkers-steeds-vaker-emotioneel-uitgeput.

[22]. De Vroege, L., & van den Broek, A. (2022). Substantial impact of COVID-19 on self-reported mental health of healthcare professionals in the Netherlands. Frontiers in Public Health, 9, 796591. https://doi.org/10.3389/fpubh.2021.796591.

[23]. Rijksoverheid. (2025, 19 december). Nieuwe berekening laat zien: zorgakkoorden kunnen personeelstekort flink verminderen. https://www.rijksoverheid.nl/actueel/nieuws/2025/12/19/nieuwe-berekening-laat-zien-zorgakkoorden-kunnen-personeelstekort-flink-verminderen.

[24]. Posluns, K., & Gall, T. (2020). Dear health care professionals, take care of yourself: An overview of self-care. International Magazine for the Improvement of Counseling, 42, 1–20.

[25] Bakker, A. B. (2009). Een overzicht van tien jaar onderzoek naar bevlogenheid. Gedrag & Organisatie, 22(4).

[26]. Gómez-Salgado, J., Domínguez-Salas, S., Romero-Martin, M., Romero, A., Coronado-Vázquez, V., & Ruiz-Frutos, C. (2021). Work engagement and psychological distress of health professionals during the COVID-19 pandemic. Journal of Nursing Management, 29(5), 1016–1025. https://doi.org/10.1111/jonm.13239.

[27] Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources and their relationship with burnout and engagement: A multi-sample study. Journal of Organizational Behavior, 25(3), 293–315. https://doi.org/10.1002/job.248.

[28]. Van Zyl, L. E., Rothmann, S., & Nieman, C. (2020). Mental health, work engagement and meaningful work-role fit of industrial psychologists: A latent profile analysis. Psychological Studies, 65(2), 199–213. Https://doi.org/10.1007/s12646-019-00544-9.

[29]. Schaufeli, W. B., & Bakker, A. B. (2003). Utrechtse bevlogenheidsschaal: Voorlopige handleiding. Sectie Psychologie en Arbeid, Gezondheid en Organisatie, Universiteit Utrecht.

[30]. Heinen, S. (2011). Het meten van werkbeleving: Psychometrische kwaliteiten van de Groninger Werkbelevingslijst. University Medical Center Groningen.

[31] IBM Corp. (2021). IBM SPSS Statistics for Windows, Version 29. Armonk, NY: IBM Corporation.

[32] Qualtrics. (z.j.). Qualtrics [Website]. https://www.qualtrics.com/

https://www.wilmarschaufeli.nl/publications/Schaufeli/Test%20Manuals/Handleiding_UBES.pdf

[33]. Kluijtmans, M., Boersma, K., & Dulk, L. (2021). Organizational conditions that influence work engagement and burnout: A qualitative study of mental health workers. Journal of Psychiatric and Mental Health Nursing, 28(5), 862–873. https://pubmed.ncbi.nlm.nih.gov/33793289/https://doi.org/10.1002/14651858.CD012527.pub.

[34]. Brugman, D. A. F., van Dam, A., van Loon, L. M. A., & Van den Broek, A. H. S. (2022). Secondary traumatisation and emotional exhaustion in mental healthcare providers: The mediating role of social support. Psychology, 13, 1865–1883. https://doi.org/10.4236/psych.2022.1313116

[35] Barros, A., Fonte, C., Alves, P., & Baylina, M. (2019). Can psychosocial work factors influence psychologists' positive mental health? Work, 63(3), 507–515. https://doi.org/10.3233/WOR-192929