The General Health of Clinical Psychologists in Scotland: Its Relationship to Experienced Stressors, Professional and Social Support, and Ways of Coping

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To my Dad,

Who taught me to question everything.

It shall be so:
Madness in great ones must not unwatch'd go.

(Shakespeare. *The Tragedy of Hamlet, Prince of Denmark*, Act 3, Scene 1.)

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'This thesis has been composed by myself and the work contained herein is my own.'

Adam G. W. Burley, August 2001

Abstract

The experience of stress by an individual can be conceptualised as a complex bio-psychosocial response that results from interactions between life stressors, the individuals personal and environmental resources, and his or her cognitive appraisals and coping styles. Stress can manifest itself in varied ways in an individual, of which anxiety and affective disorders are the primary pathological representations (Friedman, Clark, and Gershon, 1992).

The presence of support from other individuals has been described as one such resource which can alter the relationship between stressor and amount of stress experienced by an individual (Cassell, 1976). Similarly the method of coping an individual adopts in the face of stressors has been shown to have an impact upon how that stressor is experienced (Lazarus, 2001).

Stress in mental health workers is an important area to study for a number of reasons including the negative impact it can have on patients care, the sufferer themselves, and the public's impression of mental health services in general. It has also been argued that mental health professionals may be more prone to experiencing stress as a result of working in human services. There is a growing body of evidence suggesting that clinical psychologists do experience high levels of work related stress, and that this stress is related to the amount of social support they perceive themselves to have (Cushway, Tyler, and Nolan, 1996).

This study aimed to explore the relationships between the well being of clinical psychologists, the stressors they face in their work, and the support they receive in the face of those stressors. Data was collected from 180 clinical psychologists working in Scotland through self completed questionnaires via a postal survey. Questionnaires were chosen to measure demographic data, experience of life and work stressors, social and professional support, ways of coping, and general health. The associations between these measures are examined with a particular emphasis upon the relationships between the health outcome measure, and the other measured variables. The relationship of experienced stressors and general health to a range of demographic variables is also measured.

Results are discussed in relation to previous research findings, and conclusions drawn relating to the findings of the study.

1. Introduction

This piece of work is about clinical psychologists. It is about the work that they do, and their experiences of the stressors that are involved in that work. It is also about the quantity and the quality of the professional and social resources they may have available to them as working individuals, and the ways in which they call upon these resources. But perhaps most importantly, it is about their physical and mental health, and its associations with the factors mentioned above.

This introduction will examine more closely the concepts of stress, of coping, and of social and professional support, before reviewing the work already carried out in this area. Before that, and by way of placing the subject matter in context, the first section will focus briefly upon the profession of clinical psychology itself by briefly examining its history and development, its current core philosophies, purposes, and structure, and the areas and methods of work its members concern themselves with.

1.1 The Profession of Clinical Psychology

1.1.1 History and Development

The genesis of clinical psychology as a profession can be traced back to an American man by the name of Lightner Witmer, who was born in 1867, and following a career in instructing English and History between 1888 and 1891, became interested in psychological problems, and more importantly, helping people with psychological problems. He was unable to identify a course of education that would satisfy these particular interests, and so after a brief flirtation with Law, he ended up studying Philosophy at the University of Pennsylvania. Following this Witmer, like many philosophers with an interest in psychology, went to Germany, Leipzig in the case of Witmer, to study for a Ph.D. under the tutelage of Wilhelm Wundt.

On his return to America in 1892, Witmer became the director for the laboratory for experimental psychology, and worked as a psychologist in the Pennsylvania Training School for Feebleminded Children, where in 1896 he founded the first psychological clinic which he worked as director of until his retirement in 1937. During his time as clinic director he developed a number of the systems that remain as integral parts of modern clinical psychology. Within a year of the clinic opening he had developed a four week training course in clinical child psychology, and ten years after that he edited and published the first issue of a journal called, *The Psychological Clinic* which was to be concerned with all matters to do with what Witmer referred to as clinical psychology. In this journal he laid down the philosophies of clinical psychology (a term he later rejected in favour of the label 'orthogenics' - a label that never stuck!) which were centred around the understanding and improvement of human beings (Witmer, 1907). He stressed the wide range of factors that might influence, or impinge upon the development of a child, and described the psychologists role as speaking out against whatever conditions, social or otherwise, that were psychologically damaging, and to strive to promote favourable psychological environments. The goal was the optimal development of the human being at both an individual and species level. Witmer also placed a large emphasis upon clinical psychology as a scientific endeavour, stating that,

> "...in the final analysis the progress of clinical psychology, as of every other science, will be determined by the value and amount of its contributions to the advancement of the human race" (Witmer, 1907, p4).

The development of clinical psychology in Britain was influenced both theoretically and practically by the new psychological techniques being developed in America. Throughout the nineteen-twenties and thirties the British psychologist's job was

largely of an assessment and instructive nature, with an emphasis being placed upon psychometrics, objective behavioural observation, and advisory aspects primarily in the area of child guidance. Research and development of theory was seen to go hand in hand with this work. However, World War Two saw an expansion of these roles, with psychologists being called upon to collaborate with psychiatrists in areas such as personnel selection, and treatment of psychiatric casualties. This movement into the area of psychological treatment, largely as a result of major wartime staff shortages, signalled a major development for clinical psychology, incorporating the job of clinician into the more traditional role of diagnostic assessor. This development along with recognition by, and incorporation into both the British Psychological Society, and the National Health Service in the late 1940's brought about an explosion both in the numbers and areas of interest of clinical psychologists. The following years saw the development of training courses in clinical psychology, an increased level of professional regulation, and an increasing emphasis upon the clinical psychologist as an applied clinician in their own right, as well as assessor, researcher, and advisor to other clinicians.

As a relatively new profession with a large field of interest both clinically and theoretically, clinical psychology continues to grow to the present day. Their numbers have increased, their areas of interest have become increasingly differentiated, their professionalism has developed, and they have continued to keep theoretical development alive by presenting opposing positions and points of view for debate and synthesis, yet despite all this change many of the original ideas of Lightner Witmer remain identifiable.

1.1.2 Current Core Philosophies, Purpose, and Structure

In a recent publication the British Psychological Society's Division of Clinical Psychology (DCP, 2001) outlined the core philosophy of the profession. This philosophy states that the work of clinical psychologists is based upon a fundamental acknowledgement that all individuals have the same human value and the right to be treated as unique. It goes on to state that clinical psychologists will treat all people they encounter in their work with dignity and respect, and will work in collaboration with them as equal partners towards jointly agreed goals. In carrying out this work clinical psychologists will stick to and be guided by explicit statements about the ethical and professional principles underpinning their work (BPS, 1995a; BPS 1991). The purpose of the profession as defined by the Division of Clinical Psychology (DCP, 2001) is to aim to reduce psychological distress and to enhance and promote psychological health by the systematic application of knowledge obtained from psychological data and theory. Similar to Witmer's original ideas, the aims of the profession of clinical psychology focus around the enabling of individuals to cope with their daily lives and emotional needs such that their psychological and physical well being is maximised. It aims to promote self understanding, self respect, and self worth such that individuals can enjoy social and personal relationships and utilise commonly valued social and environmental agencies. Furthermore the profession aims to inform other professions and service users of psychological knowledge so as to maximise psychological well-being at a clinical, organisational and societal level.

The majority of clinical psychologists work within the NHS, and there is an intimate link between the NHS and training in clinical psychology forged by the decision of the Whitley Council in 1981 (Liddell, 1983b) to make a formal postgraduate

qualification an obligatory condition for individuals wishing to be employed as clinical psychologists within the NHS. The training structure has developed somewhat from Witmer's four week course, and within Britain is now a three year full time training leading to the degree of Doctorate in Clinical Psychology which is recognised by the NHS executive as qualification allowing practice. The training comprises three key elements of clinical practice, academic teaching, and research activity, with supervised clinical practice making up at least half of the training time. Clinical work typically involves experience of working within four core areas of adult mental health, learning disabilities, child and family, and older adults, with options for specialist placements available throughout the training. Such a program gives trainees a wide range of experience with different client groups, across age ranges, and across settings, and is presumed to be an effective model of training, although some have argued that there is no empirical evidence for its effectiveness and a more flexible skills based approach may be more appropriate (Binder, 1993; Milne, 1998).

Clinical psychologists professional behaviour is monitored and maintained through the processes of chartering and adherence to guidelines for good practice that are issued by the Division of Clinical Psychology (BPS, 1995a). To become a chartered clinical psychologist requires a degree in psychology and a further three years of supervised practice or accredited training. Chartered psychologists agree to abide by the British Psychological Society's code of conduct and can removed from the register of chartered psychologists for breaching that code.

Within this structure, and in line with the core philosophies and aims, the profession has grown exponentially and can now be found working in many areas of healthcare (Napier, 1995).

1.1.3 The Areas of Practice, and Practice Methods of Clinical Psychologists

Clinical psychologists work with a wide range of people at both an individual and group level. Those commonly using the services of clinical psychologists are those with mental health problems, with learning disabilities, children and their families, those who have suffered stroke or head injuries, forensic populations, and those with general or specific physical health problems. The settings in which clinical psychologists work are equally diverse incorporating acute and general hospitals, primary care teams, social services, prisons, residential facilities, and day care facilities. A small percentage of clinical psychologists can also be found working either part time or exclusively in academic setting providing training and/or pure and applied research.

A recent report on psychology services in Scottish healthcare (Reid, 1999) listed twenty two areas in which clinical psychologists were employed, with adult mental health being the largest specialty area, with 43.55% of all posts. Learning disabilities and child and family posts made up 20.67% and 14.84% of total posts respectively, with specialties such as older adults, neuropsychology and health psychology making up between 0.03% and 5.32% of total posts. The report concluded that the main areas of practice of clinical psychologists were in mental health, learning disabilities, and child and family while other specialties were so small and fragmented that their continued viability was at risk (Reid, 1999).

The methods of practice of clinical psychologists are often described as falling under the four headings of assessment, formulation, intervention, and evaluation. The technique of psychological assessment has perhaps the longest history within the profession with early clinical psychologists being viewed primarily as psychometric assessors. Modern clinical psychology still places a large emphasis upon the development and use of psychometric instruments, but also draws upon behavioural observation as well as formal and informal interviews as methods of assessing psychological state. Results of assessments are viewed within the historical and developmental context of the individual or system being assessed, and lead naturally on to formulation and intervention design (Liddell, 1983b).

Formulation refers to the process whereby the information gained from assessment is integrated to provide a framework for understanding a psychological process in terms of its development and maintenance. In formulating a clinical problem the clinical psychologists draws upon a wide range of psychological theory and models, and arrives at hypotheses regarding the nature of the problem which may point to particular interventions.

Interventions can take the form of direct psychological therapies, indirect interventions such as training or teaching, or consultancy to other care providers, the results of which are evaluated and used to test the hypotheses and modify the original formulation. Psychological therapies, from behavioural therapy to psychodynamic therapies are now a major part of the clinical psychologists work (e.g. DeRubeis and Crits-Christoph, 1998). This is in contrast to a position as short a time ago as 1949 when a leading English clinician reported the two major functions of clinical psychologists as research and diagnosis, and that psychotherapy was not an

appropriate role due to the fact that treatment was a medical issue, it diverted interest away from research and diagnosis, and it required a bias on the part of the provider such that objective evaluation was not possible (Eysenck, 1949). Despite this the clinical psychology literature, and the predominant areas of psychologist employment, clearly show that the delivery of psychological therapies is a major constituent of the work of present day clinical psychologists (DCP, 2001).

However, clinical psychologists do more than psychological therapy. The practice of clinical psychology is often referred to as operating within a scientist-practitioner framework which emphasises the importance of designing and carrying out applied research as a matter of course. This focus on research is reflected in the training where it is taught to a doctoral level, and it is expected that research activity is integrated into any clinical work carried out. In theory each new case or problem can be viewed as an opportunity to draw upon, and add to psychological theory through the process of a scientific approach to clinical practice. However, small and large scale studies investigating the research activity of clinical psychologists indicate that despite the emphasis the profession places upon this aspect of work, the published research output is produced by less than 10% of practicing clinical psychologists (Brems, Johnson, and Galluci, 1996; Burley, 1999).

1.1.4 Summary

In summary, clinical psychologists can argue a unique position within the NHS, as assessors of psychological difficulties, advisors on psychological care, providers of psychological therapies, and producers of clinically and theoretically important research. This combination of competencies drawn from an ever developing body of

psychological theory allows them to help solve problems of a personal, group, and organisational nature from a position unlike any other health professional.

This cursory examination of the profession carries within it suggestions of the potential stresses of working as a clinical psychologist, such as working within a developing profession, and with emotionally vulnerable people. The professional practice guidelines published by the Division of Clinical Psychology acknowledge this potential, and highlight the importance of psychologists maintaining their own physical and psychological well-being as a condition of effective practice, and highlight the client/therapist relationship and organisational factors as potential sources of stress. The guidelines state that it is the duty of the psychologist to seek support and guidance in an effort to cope with sources of stress and to resolve any ongoing distress (BPS, 1995a).

Before examining these sources of stress, and their impact upon clinical psychologists in more detail, the concepts of stress, coping and support will be defined and discussed in some more detail.

1.2 Stress

1.2.1 Definitions

The term stress is used widely and in a multitude of ways both in every day parlance and within psychological literature (Paykel, 1995), and as such a clear definition of the concept is important in this study. Evans (1998) comments on the various uses of the term stress, and describes a useful system of definition referring to stress as occurring either in the outside world, or within an individual; stress outside and stress inside. Other theoreticians have used the term stress to refer to a process that

takes into account both internal and external variables (e.g. Lazarus and Folkman, 1984)

1.2.2 Stress Outside: Stressors

Stress outside refers to events or situations that either happen to a person, or a person exists within. Research has tended to focus upon events or situations that nearly everyone is likely to be exposed to at one time or another during their lifetime, such as marriage, the birth of a child, and bereavement. Such events can be further categorised as either transitory outside stresses, often referred to as life events (Kessler, 1997), and more long term outside stresses, often referred to as chronic stress (e.g. Brown and Harris, 1978). Important in these definitions of outside stressors is the idea that the event or situation carries with it some potential to bring about a negative change in the individual experiencing them, and there is evidence suggesting that the particular life events and chronic situations, such as illness, job loss, and financial hardship carry an inherent stress (Sarason, Johnson and Seigel, 1978).

These definitions also allow stress to be viewed as an independent variable which can be measured and manipulated in various ways, allowing experimental designs that measure associations between events and situations and the effect these have upon the individual (e.g. Kessler, 1997). Despite the attraction of defining stress as a measurable external construct, Evans (1998) points out that such a definition does not provide any information about why certain people react to the same situation in different ways, and as such is an incomplete definition of stress.

For the purposes of this study Evans' concept of stress outside will be referred to as *stressors*, either transitory or chronic, and will be used to denote any situation or

event that occurs within an individuals environment that has the potential to cause that person to experience a negative change in their psychological or physical well being.

1.2.3 Stress Inside: Psychological and Physical States

The experience of relative psychological or physical well being can be thought of as the stress inside (Evans 1998). In this definition stress is the internal responses of the individual to the external stressors, the behavioural and psychological expression of their state of well being. In its simplest form this definition would allow us to gain an idea of how much stress someone is suffering from by examining these internal states independent of the situation or event they are facing. Friedman, Clark and Gershon (1992) suggest that in humans these stress responsive states are primarily of an anxiety or depressive nature. However, defining stress purely as an internal state says nothing of its origins, and the measurements used to measure stress inside at any given time may be confounded by more longer term factors such as personality type, and chronic mood states (Dewe, Cox and Ferguson, 1993).

Within this study what Evans terms stress inside will be referred to in a number of ways such as *psychopathology, psychological adaptation, psychological well being, psychological distress,* and *mental health,* and will refer to an individuals subjective experience of his or her psychological state, at any one point in time.

1.2.4 Associations Between Stressors and Psychological Well Being

The two definitions of stressors and psychological adaptation suggest a simple model whereby external stressors directly bring about a variety of internal psychological adaptations in an individual. Such a model has been termed 'the victimisation model'

by Dohrenwend and Shrout (1985) and can be represented diagrammatically in the following way;

Figure 1.1 The victimisation model of stress

There is a body of research that has focused upon the direct associations between stressors and psychological adaptation, with the emphasis usually being on the impact of transitory stressors such as life events on psychological well being (Paykel, 1995). In particular depression has been strongly associated with an increased number of life events prior to onset (Kessler, 1997; Paykel, 2001), and such associations have also been shown to hold true in children and adolescents, (Goodyer, Kolvin, and Gatzanis, 1987), and older adults (Murphy, 1982), as well as in general adult populations. Kessler (1997) in reviewing the work on association between life events and depression concludes that although there is consistent evidence for a strong link, it is clear that the relationship can be reciprocal and that depression can elicit or increase the impact of certain stressors. Also, the association varies considerably depending upon inherent characteristics of the individuals and the nature of their environmental context. However a recent study by Monroe, Harkness, Simons, and Thase (2001) demonstrated specific associations between life events and particular manifestations of psychopathology. They found that life stress was associated with cognitive-affective symptoms of depression, and not somatic symptoms, and that this association held true only for events occurring prior to onset of depression. Furthermore they found a particularly strong association between

severe events occurring before onset, and levels of suicidal ideation. They conclude that symptom severity and duration in depression is associated with severe stressors occurring prior to onset, and not after onset.

Friedman, Clark and Gershon (1992) review the associations between stressors and anxiety and report that although clear associations have been demonstrated between stressors and anxiety disorders such as Post Traumatic Stress Disorder, there is less evidence for similar relationships in panic disorder, or obsessive compulsive disorder, although Friedman *et al.* (1992) do report some evidence for an association between increased numbers of life events preceding the onset of agoraphobia.

Such associations between stressors and psychological adaptation are supported by a range of psychological models such as Seligman's (1975) animal model of learned helplessness where the experience of an uncontrollable stressor, brought about behavioural alterations consistent with depression. Brown and Harris (1989) forwarding a sociological theory of depression, also demonstrated such an association in a non-clinical human population where transitory and chronic stressors were highly associated with the aetiology of depression.

In summary there is a body of evidence suggesting strong associations between stressors and psychological adaptation, particularly in psychiatric conditions such as depression (Kessler, 1997), and to a lesser degree in disorders such as schizophrenia and manic depression (Paykel, 2001).

Such associations point to a role for stressors in the production of psychological states such as depression and anxiety but say little about the undoubtedly complex mechanisms and processes underlying them. Paykel (2001) also points out some of the difficulties inherent in life events research. According to Paykel three major

difficulties exist. The first of these is the over reliance on memory, because nearly all life event data is collected retrospectively and as such is subject to memory biases. Second, is the problem of direction of causality. Put simply the associations do not provide a clear idea as to whether increased rates of stressors such as life events cause psychological states such as depression, or whether psychological health can bring about increased rates of life events. For example Kendler, Karkowski and Prescott (1999) showed that about a third of the relationship between life events and depression was non-causal, and was brought about by individuals 'self-selecting' into high risk environments. Other studies, such as the long term follow up studies of Champion, Goodall, and Rutter (1995), and Van Os and Jones (1999), indicate that the experience of psychological distress is strongly correlated with increased rates of life events, both of a person dependent and independent nature, at future times.

The third difficulty Paykel (2001) highlights is that of quantifying the amount of psychological distress caused by a particular event. For example an individual suffering from a depressive episode is likely to perceive a historical event differently from an individual who is not depressed. In other words, an individuals present state of mind is likely to influence their impression of how much of a stressor a previous life event was.

These difficulties combined with the lack of explanatory power these associations provide suggest a more complex model of stress is required that describes more fully the interaction between stressors and psychological adaptation. As Friedman *et al.* (1992) conclude, although stressors may lead to the occurrence of a finite number of behavioural and psychological responses in an individual, such as anxiety and

depression, the process by which this occurs is a dynamic one composed of multiple components.

This idea of stress as a process between an individual and his or her environment will be discussed next.

1.2.5 Stress as a Process: Transactional Theories of Stress

In conceptualisation of stress as a process, stress is seen not as existing within the individual, or in the environment, but within the interplay or transaction between the two. For this reason such models are often referred to as transactional models of the stress process (Cox, 1990).

Perhaps the most pervasive and enduring model of stress as a transactional process is that forwarded by Lazarus and Folkman (Lazarus and Folkman, 1984). Following their studies examining how providing different information to individuals regarding the nature of a potentially stressful film could moderate their physiological arousal, they concluded that an individual's appraisal of a stressor was central in determining their adaptation towards it. According to Folkman and Lazarus, the psychological adaptation of an individual is best viewed as the product of a balance between the demands of the stressor and the individual's capacity to deal with those demands.

Poor psychological outcomes are seen to occur when the demands are perceived by the individual to outweigh (or as threatening to outweigh) their perceived capacity to deal with those demands. Central to this idea is the concept of the cognitive appraisal of an event or situation, and of the resources available to the individual, both personal and environmental, that may be used to deal with any demands. The idea of cognitive appraisal is closely linked with the concept of coping and will be discussed briefly in the next section. Dewe, Cox and Ferguson (1993) highlight the importance

of identifying clearly the constituent parts of stress as a process. The transactional model can be thought of as having three important components; The idea of the stress process as a dynamic cognitive state, that represents a disruption in balance between perceived external demands and perceived coping resources, and that gives rise to a requirement for a resolution of that imbalance.

A further aspect of the transactional approach is that something must be at stake for the individual if they are to perceive a situation or event as stressful. Cox (1990) describes how it is through the appraisal mechanism that an individual decides if there well being is being harmed, threatened, or challenged in some way, and it is the result of that appraisal that provides the motivation and direction of the desire for resolution.

The transactional model of the stress process can be represented diagrammatically in the following way;

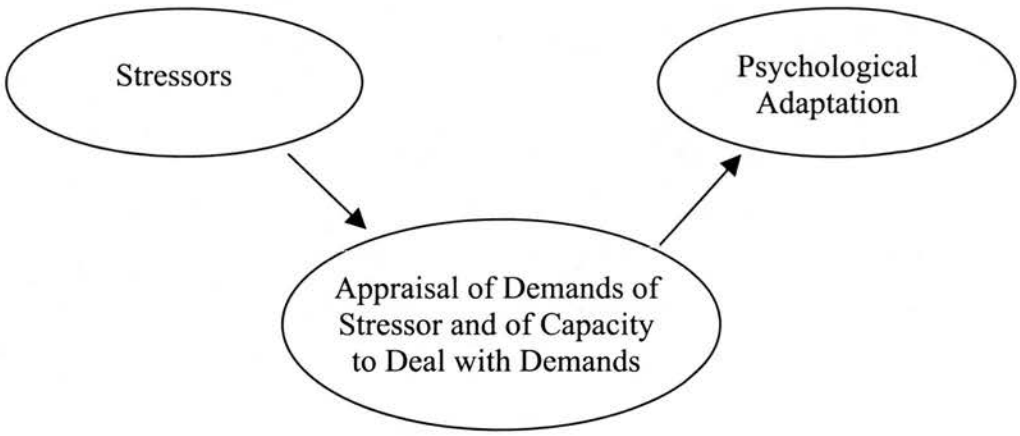


Figure 1.2 The transactional model of the stress process

In this model a stressor does not in itself carry any inherent damaging quality, instead the experience of psychological distress arises from a discrepancy between what the

individual perceives to be the stressful aspects of a stressor, and their perception about their own abilities to deal with those aspects.

As Lazarus (2000) summarises, the bottom line of this approach to conceptualising the stress process is,

> ".. the *relational meaning* that an individual constructs from the person-environment relationship. That relationship is the result of appraisals of the confluence of the social and physical environment and personal goals, beliefs about self and world, and resources." (Lazarus, 2000, p 665).

The transactional model goes further than the victimisation model by highlighting the role an individuals personal characteristics and environmental resources may play in the stress process. The model predicts that personal characteristics such as coping strategies, and available resources such as support networks mediate the relationship between stressors and psychological adaptation (Aldwin and Revenson, 1987). Such a formulation places the individual and their resources, both internal and external, very much at the heart of the stress process.

Within this project the stress process is viewed in accordance with the transactional model of stress initially proposed by Lazarus and Folkman in 1984. The model highlights three aspects apart from stressors and psychological adaptation that are central to the stress process; appraisal, coping and the concept of available resources. In the following three sections each of these will be examined more closely. Appraisal will first be discussed briefly, followed by a closer examination of the concept of coping, before a discussion of two potential resources an individual, and more specifically a clinical psychologist, may use in response to stressors; social and professional support.

1.3 Appraisal

1.3.1 Appraisal Theory

The concept of appraisal has arisen in a number of contemporary theories linking cognition and emotion (e.g. Beck, 1976; Power and Dalgleish, 1997). Such appraisal theories are concerned, in general, with the importance of the interpretation of stimuli with regard to oneself. The term, 'appraisal' was first coined by Magda Arnold (Arnold, 1945) who theorised that as human beings we immediately and automatically appraise all that we encounter as a fundamental act of the perception process that precedes action. The basis for these appraisals according to Arnold is the memory of similar past experiences, along with their associated affective reaction, and it is these along with expectations about the consequences of our actions that lead to behavioural choice. Arnold stressed the speed, and innate, intuitive nature of the appraisal process, and although the theory was developed without reference to modern concepts of cognition it did anticipate the more current approaches.

1.3.2 Cognitive Appraisal

Theories of cognitive appraisal focus explicitly upon an individual's knowledge of their circumstances, and how these cognitive appraisals lead to emotional responses (Ellsworth and Smith, 1988; Smith and Ellsworth, 1987). Central to the idea of cognitive appraisal is that individuals appraise a situation along different dimensions, and these dimensions determine their specific emotional reaction. Ellsworth and Smith emphasised the importance of an individuals appraisal of the pleasantness, agency (responsibility of control by oneself or another), uncertainty (how much understanding one has of the situation), and attention (how much attention is warranted to the situation), in determining the associated emotional reaction.

1.3.3 Personal Meaning

More relevant to the process model of stress outlined in the previous section, Lazarus (1966) viewed an individuals appraisal mechanism as consisting of an evaluation of any given stimulus according to its personal significance for that individuals well being. This differs from the straightforward cognitive appraisal model in that it focuses more specifically upon personal motivational meaning (e.g. Lazarus, 1966; Lazarus and Smith, 1988). In this framework two processes of appraisal occur; primary appraisals, and secondary appraisals. The primary appraisal is the process whereby an individual appraises the personal relevance of a situation in reference to their own held beliefs, goals and concerns. This appraisal also includes an evaluation the facilitating or impeding nature of the stimuli. Emotional responses to these primary appraisals were viewed by Lazarus to be of a primitive nature, being simple reactions to the potential harm or benefit any given situation (Lazarus, 1993). The primary appraisal process can be represented diagrammatically in the following way;

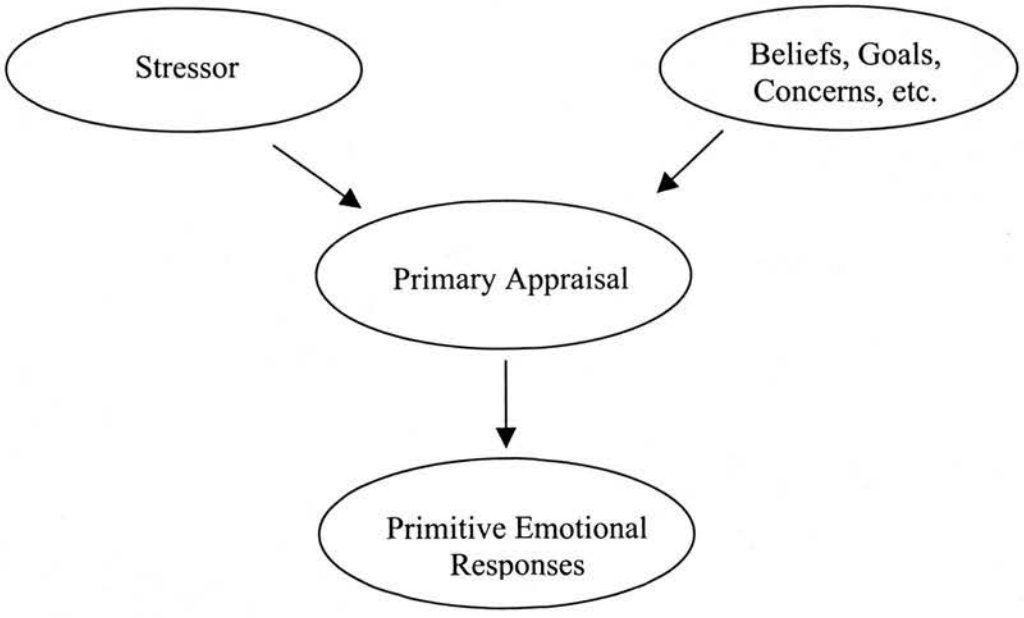


Figure 1.3 The primary appraisal process

The secondary appraisal processes involves an evaluation of what the individual can do in response to the stimuli. This would typically involve an appraisal of individual capabilities and resources, as well as an evaluation of any resources available within the individuals environment. Lazarus proposed that these secondary appraisals lead to the choice of a particular coping strategy, the outcome of which will result in different emotions. The secondary appraisal process is represented diagrammatically as follows;

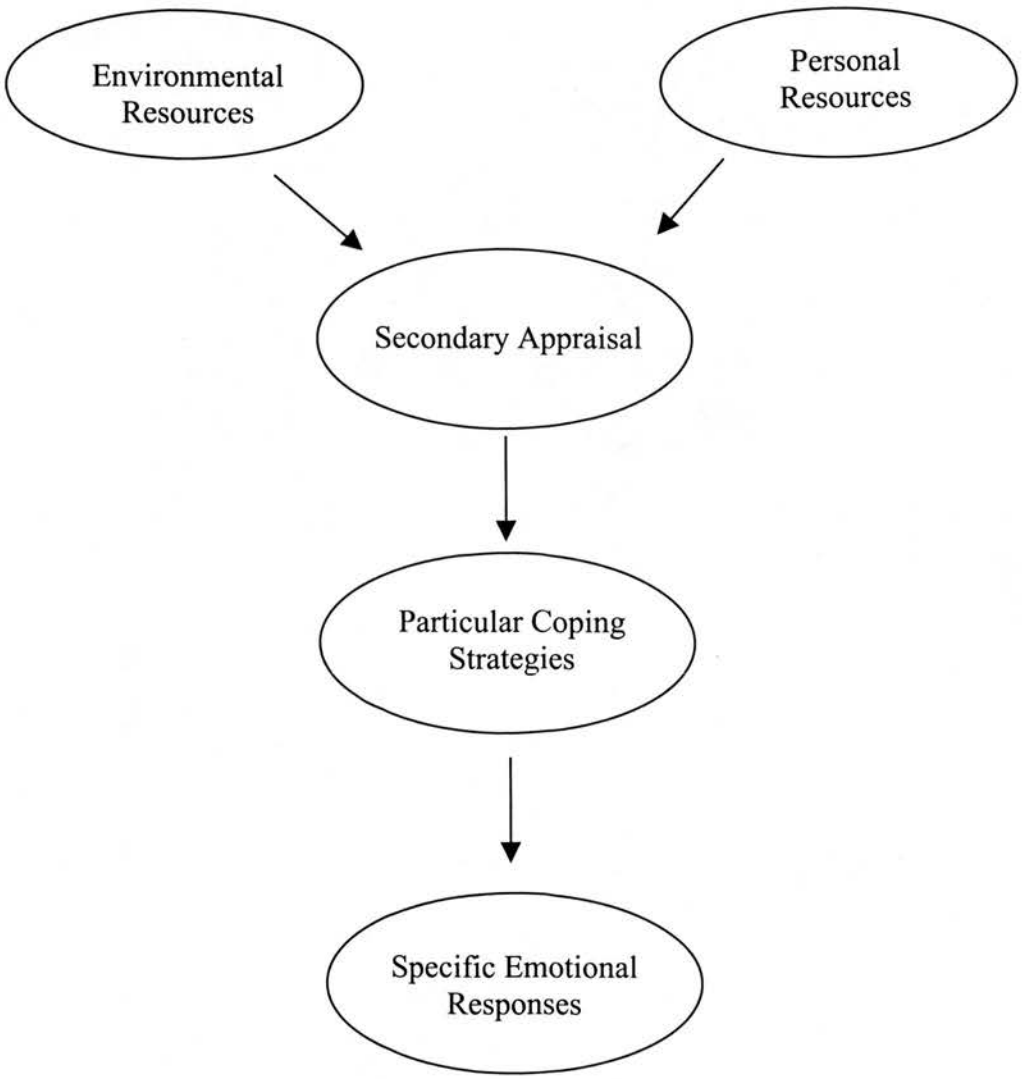


Figure 1.4 The secondary appraisal process

An important aspect to these appraisal mechanisms is that although they may be presumed to be rational in nature, they are more than likely to be somewhat less than that, and follow patterns idiosyncratic to the individual and his or her particular belief systems and previous experiences (Edwards, 1988).

Within the transactional model adopted for this project appraisal is therefore seen as the process whereby any given situation is denoted meaning by an individual through a process of assessing whether the encounter is stressful (primary appraisal), and of what is available to deal with it (secondary appraisal). The convergence of the products of these appraisals is what initiates the coping process.

1.4 Coping

1.4.1 Definitions

Coping, like the concept of stress has been subject to multiple definitions. Up until the 1970's coping research was most commonly defined in ego psychology frameworks. Within this model coping strategies were descibed as ego-defenses which served to deal with threats to an individuals psychological integrity through processes such as ego enhancement, conciliation, and escape mechanisms (Ausubel, 1996). Within this formulation particular expressions of psychopathology were associated with particular defensive styles which were seen to be characteristic of the individual. For example, hysteria was viewed as resulting from repressive defenses, obsessive compulsive presentations as eminating from an intellectualisation defense, and paranoid psychopathology occuring as a result of projection (Ausubel, 1996). Such a view arises from the assimilation of three aspects of Freudian theory; the psychosexual stage of development at which trauma occurs; the primary impulses and conflicts of each particular stage; and the child's particular cognitive repertoire at

that stage, which combine to determine the nature of the defense adopted and thus the psychopathology. Coping, or the need for defense, in this model is motivated by a drive to reduce anxiety brought about by psychic conflict. As Ausubel (1996) states;

> "The psychopathological basis of most defense mechanisms lies in the imperious need for anxiety reduction. Defense efforts are elicited even before anxiety appears, that is, as self-esteem first begins to be threatened; and when the threat becomes intense enough to evoke the affect of anxiety, the original need for defense becomes even more imperative." (Ausubel, 1996, p 255).

Defense mechanisms are arrived at unconsciously (Malan, 1995), and so assessment of them relied upon subjective clinical observations, projective techniques, or some other form of open ended response procedure (Cohen, 1987). The lack of supporting evidence for the clear links between defensive style and psychopathology the model predicted, combined with the difficulties with objective measurement, provided grounds for criticism of ego psychology as a model for studying the coping process (Lazarus, 1993).

The transactional models of the stress process outlined above operationalised coping as a more conscious process. Within this framework perhaps the most influential definition of coping comes from Lazarus and Folkman's original thesis on the transactional moel of stress and coping, in which coping is described as,

> "..constantly changing cognitive and behavioural efforts to manage the specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person." (Lazarus and Folkman, 1984, p 114).

Unlike the ego psychology model, the transactional model views coping as a range of thought processes and behaviours that occur in response to specific stressful situations, as opposed to an enduring personality characteristic. Here, coping is a process which is dynamic, changing over time in response to the appraisals of the demands of any given stressful situation.

The ego psychology definition and the transactional definition are just two definitions from over thirty that exist within the stress and coping literature (Latack and Havlovic, 1992). Other definitions highlight different aspects of the process of coping, and it has been variably described as a psychoanalytic process, a personal trait or style, a set of behavioural stages, and as a taxonomy of discrete responses (e.g. Folkman and Lazarus, 1980; Cox and Ferguson, 1991). Dewe, Cox and Ferguson (1993) provide a critique of the variety of approaches descibed in the literature and propose that three common themes can be extraploated from the diverse definitions. The first of these is the relational aspect of coping. This states that coping should be seen as reflecting a relationship between the individual and the environment. Secondly, coping should be viewed as a process as opposed to the more traditional view of a coping as a robust character trait, or individually discrete set of responses. Third and finally, coping should be integrative allowing an understanding of how it relates to other aspects of the stress process. In keeping with these three themes Dewe *et al.* (1993) define coping as,

> "the cognitions and behaviours adopted by the individual following the recognition of a stressful encounter, that are in some way designed to deal with that encounter or its consequences." (Dewe, Cox and Ferguson, 1993, p 7).

They go on to emphasise that although the coping process can be viewed as existing within a linear model somewhere between stressors and health, the relationship is likely to be of a complex nature involving both feedback and feedforward loops.

1.4.2 Coping as a Style versus Coping as a Process

An examination of the above definitions of coping reveals a number of similarities in that they all describe some form of action by an individual in response to a situation or stimuli they find threatening in some way. However, one area of divergence between definitions is that of whether coping represents a stable, trait or style, or whether it is better conceptualised as a dynamic process that changes across situations and time.

Coping as a style refers to the idea that coping activity is representative of a finite number of character traits that an individual may possess and use across different situations. Coping behaviour is viewed as habitual and stable, and as such the model assumes that situational variability is relatively unimportant in the study of coping (DeRidder, 1997). Such a viewpoint can be seen to originate within the psychoanalytic models of defense mechanisms that are employed across different situations and are representative of underlying personality structures (Lazarus, 1993). In this model coping can be viewed as the personality in action under stress (Bolger, 1990), and coping strategies as dispositional in nature, and therefore consistent across time, and across personality type (Costa, Somerfield, and McCrae, 1996). This dispositional approach to the formulation and study of coping reduces the complexity of coping research and is implicit in many studies into coping (Miller, 1992). The dispositional view can be represented diagramatically in the following way;

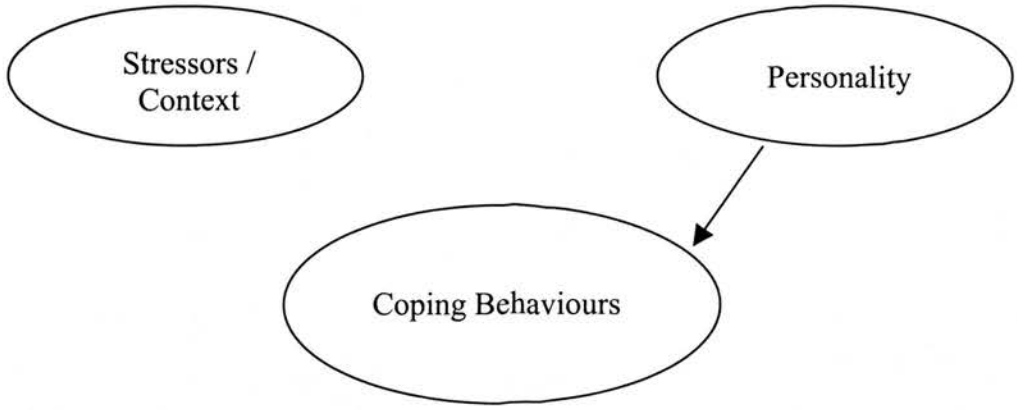


Figure 1.5 A dispositional model of coping

The model of coping as a process proposes that coping is a dynamic, context specific response to a stressor (Lazarus, 1993). This approach attempts to look at the coping behaviours of individuals across different situation in an effort to understand the associations between particular coping behaviours and particular stressors (Carver and Schier, 1994). The coping as process view can be represented diagramatically in the following way;

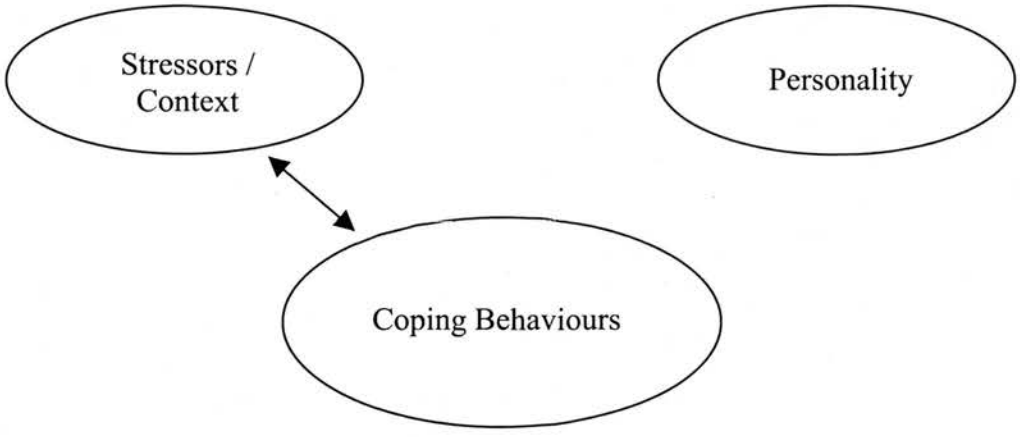


Figure 1.6 A process model of coping

Lazarus (1993) describes the five key components of the coping as process approach. The first of these is that coping actions must be viewed sperately from their outcome,

as there is no direct link between a coping behaviour and an outcome. Secondly, coping method should be tied as directly as possible to a particular threat, as different threats may elicit different strategies. Thirdly, coping should be defined by what an individual is *actually* thinking and doing, not what they remember thinking or doing. Fourthly, coping should be thought of as ongoing attempts by an individual to manage stressors appraised as threatening to their resources. Lastly, the process approach emphasises that there are two major functions of coping; reducing its emotional impact (emotion focused coping), or modifying the stressor in some way such as to reduce its impact (problem focused coping).

Data regarding situational vartiability in patterns of coping is scarce due to a shortage of longitudinal studies (DeRidder, 1996). There are however a few studies suggesting that people use different patterns of coping behaviour depending upon the nature of the stressor they are facing (e.g. Dolan and White, 1988; Folkman, 1992). For example, Folkman (1992) cites evidence suggesting that the coping behaviour of seeking support from others is a more situation dependent response than positive reappraisal, which appears to have more to do with personal characteristics. In another study Patterson, Smith, Grant, Clopton, Josepho, and Yager (1990) showed that when facing similar stressors at different time periods individuals who relied on problem focused coping did so consistently, whereas emotion focused coping changed across time periods. Furthermore they found that events appraised as changeable brought about more problem focused coping than emotion focused, an idea suggested by Lazarus (1993) who proposes that although problem focused coping may be more culturally acceptable, emotion focused coping may be more appropriate in the face of stressors that are unamenable to change. Interestingly,

Patterson *et al.* (1990) found that the only demographic variable that influenced coping behaviour was that of age, with problem focused approaches dropping off in frequency as age increased.

However, despite these findings there is a growing body of evidence suggesting that coping behaviours may remain fairly constant across time and across situations. For example a recent study by Frazier, Tix, Klein and Arikian (2000), carried out structural equation modelling on longitudinal coping and social support datasets. Their results indicated that coping behaviours remained consistent over time, and across situations and were not influenced by other measured factors such as social support. Other longitudinal studies have produced similar results (Costa *et al.* 1996; Watson and Hubbard, 1996), suggesting that coping is best conceptualised as representative of a trait rather than a state.

Historically, a polarisation between the two positions outlined above has tended to run through the coping literature with researchers arguing strongly for either one model or the other in their work. More recently however, a rapprochement appears to have developed whereby both viewpoints are seen as valid approaches to studying the coping process (Suls and David, 1996). For example, Lazarus (2000), traditionally a staunch advocate of the coping as a process position, reports how both trait and process measures are important in the study of coping if a clearer idea is to be gained of the micro-processes that occur within the coping process, and how these change over time and across situations. Suls, David and Harvey (1996), refer to this as the, 'third generation' of coping research, represented by a focus on the role personality plays in determining coping behaviours, as well as a commitment to strong operational distinctions among coping, personality and adaptional outcomes.

On the face of it the two positions do appear to be compatible if thought of as representing two different ways of viewing the same phenomena, each with its own logical and empirical validity. It seems logical that individuals will respond slightly differently to different stressors at different times, but it also seems logical and consistent with well established psychological theory that those responses are likely to fall within a finite range that will differ from individual to individual dependent upon their particular developmental, psychosocial and coping history (Malan, 1995; Kernberg, 1984; Aldwin, Sutton, and Lachman, 1996).

Therefore it is not too surprising to find that empirical evidence can be found for coping behaviours both changing *and* remaining to some degree constant across situations and over time. In other words it seems plausible that while individuals can respond in a variety of ways in the face of stressors, a longitudinal examination of these responses will show consistencies within individuals. This third generation model can be represented diagramatically in the following way;

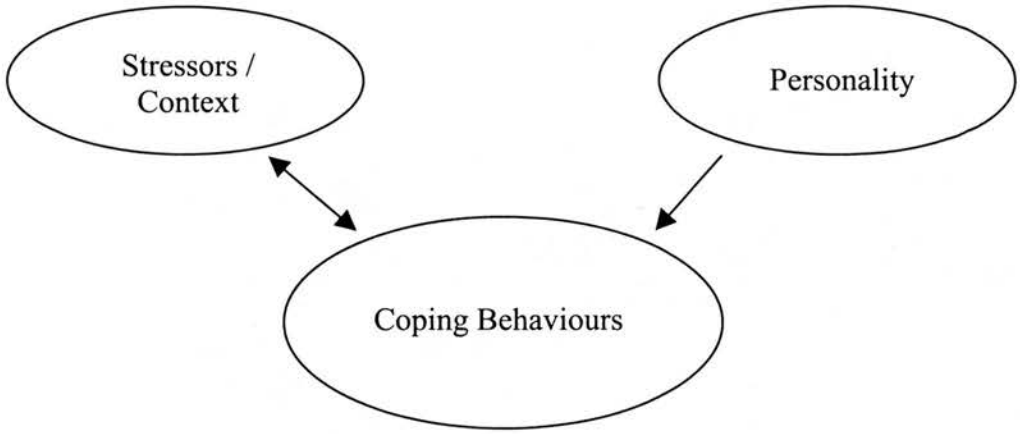


Figure 1.7 A third generation model of coping

While such a position has been developed among coping theoreticians, it is still to be used widely within empirical research (Suls *et al.*, 1996).

1.4.3 Dimensions of Coping

Central to all of the definitions of coping described above is the idea that coping involves responses, either of a cognitive or behavioural nature, on the part of the individual. Due to the hugely varied nature of human response, it has been important within the coping literature to classify responses according to their functional nature. Parker and Endler (1992) in a critical review of coping assessment found that the most commonly used dimensions used were, 'problem-focused' and, 'emotion-focused' as initially described by Folkman and Lazarus (1980). In this classification problem-focused coping behaviours are those designed to bring about some actual change in the stress inducing phenomena, while emotion-focused coping refers to coping behavours that attempt to change the level of attendance to the stressor, or change the meaning it conveys to something more benign. In this second, emotion focused, case the stressor itself is not changed, rather its meaning is changed in the mind of the individual (Lazarus, 1993).

Another common classification method is that of distinguishing between, 'avoidant' and, 'approach' forms of coping. In this system avoidant coping behaviours refer to those behaviours which bring about a distancing or denial of the stressor to the individual, while approach coping behaviours are those where the individual actively attempts to do something about the stressor (Billings and Moos, 1982).

These are by no means the only categorisations present in the literature, and Endler and Parker (1992) identify different systems which define between thirteen and twenty eight dimensions of coping. Folkman (1992) suggests that any dimension system should have at least two categories, and no more than eight, so as to preserve

some detail, and at the same time prevent an overwhelming number of combinations from being produced.

A somewhat novel system of categorisation was proposed by Cox and Ferguson (1991), who presented a convincing argument suggesting that *all* coping behaviour serves one overriding function of dealing with the emotional correlates of stressors, and establishing a sense of personal control. Above and beyond this they suggest that particular coping strategies may serve three functions; problem-solving, event reappraisal, and avoidance, and that any one strategy may serve one or more of these functions to some extent. All three functions are used to reduce the emotional consequences of facing a stressor, but they propose that the avoidant strategies may be the most directly associated with emotion management. Dewe *et al.* (1993) in reviewing work on coping strategies among workers experiencing stress, found that their data fitted better with Cox and Ferguson's dimensions than with the more traditional category systems of Folkman and Lazarus (1980), but proposed that their data could be compatible with the emotion / problem focused dimensions if a further dimension of re-appraisal was to be added. Such a system is in line with three dimensions proposed by Billings and Moos, namely, emotion focused, problem focused, and appraisal focused coping strategies (Billings and Moos, 1984).

DeRidder (1997) highlights some further difficulties that have arisen within the categorising of coping behaviours, in particular what should be included as a coping behaviour and what shouldn't. For example some authors have argued that only observable behaviours ahould be viewed as legitimate for study, whilst others have argued that only cognitive activity should be thought of as coping. In summarising the work on categorisation, DeRidder concludes:

> "To summarize, one could argue that the lack of clear theoretical views is an important obstacle in categorizing ways of coping." (DeRidder, 1997, p 423).

This statement is not too dissimilar to the conclusions of Dewe *et al.*'s (1993) review which reports that the question of how coping is classified remains open, suggesting that the problem of dimensions is not new to coping research and is still prevalent in the literature (e.g. Lazarus, 2000).

1.4.4 Coping Measurement

The measurement of coping is intrinsically tied up with the above discussion on definitions and dimensions of coping, as tools for measuring a process are typically designed with a theoretical understanding of that process in mind. Given the wide number of different theoretical positions researchers have taken on the concept of coping it is no surprise that there are a wide range of coping measures available. In a recent review, DeRidder (1997) identifies twenty five different measures, none of which are equivalent on the three components of; trait or process measure, number of dimensions, and number of items in the measure.

Coping measures have traditionally taken the form of self report checklists that describe a number of coping behaviours that an individual might engage in, and ask the individual to report how frequently they use or have used that particular coping behaviour in general or in response to a specific stressor. One important aspect of any coping questionnaire is the wording of the question. Newton (1989) points out how the wording of the question being asked can influence the construct being measured. For example wording that asks for a response regarding general coping behaviour is likely to be tapping into the coping style of an individual, that is how he or she thinks they respond to stressors in general. However wording that asks the

respondent to think of a particular type of stressor, or an actual stressor they have recently experienced can be assumed to be asking for something more specific than a coping style. Such an approach is more in line with Lazarus' (1993) definitions of assessing coping as a process that is context dependent.

While it is an appealing idea to measure coping in this way, both in terms of the relative speed and ease of use of the measures, there are a number of difficulties with the approach. For example, Oakland and Ostell (1996) point out that there is a tendency for some of the items on checklists to suffer from a lack of focus. For example an item such as, 'Talked with others about the problem', could have served a number of purposes for the individual ranging from letting off emotional steam, to asking for constructive advice. As such an endorsement of that item by the individual, and the meaning the researcher takes from that endorsement could reflect very different things. In essence the construct validity of most measures is at best poor (DeRidder, 1996). DeRidder also points out the general lack of reliability of coping questionnaires, a problem which is confounded by the concept of coping changing over time and situations. The difficulty here is proving the reliability of a tool that is designed to measure behaviours which are likely to be different at the initial test time and at the retest time.

Another potential difficulty with coping checklists is that an endorsement of frequency of a particular coping behaviour does not necessarily mean that the behaviour being endorsed is adaptive for the individual. This is important when associations are being made between measures of coping and measures of psychological well being, because the assumption is that any associations observed reflect a genuine link between the two constructs. In fact it could be the case that the

most frequently endorsed coping behaviours are not the coping behaviours that are effective, and as such have little to do with the outcome. In other words, the checklist approach gains a measure of what coping behaviours an individual reports doing, but does not say anything about the effectiveness of these behaviours. As Oakland and Ostell describe,

> "In summary, what these contradictory and inconsistent findings suggest is that a particular coping strategy cannot be valued as and labelled as "effective" or "ineffective" without reference to the context in which it is used." (Oakland and Ostell, 1996, p 140).

As well as these difficulties, checklist measures suffer from the same biases that other retrospective self report measures do such as biases from memory, social desirability, underreporting, overreporting, and miscomprehension (Evans, 1998). Despite these problems the measurement of coping behaviours through the use of self report checklists is by some way the most commonly used technique in coping research (Parker and Endler, 1992; De Ridder, 1996).

1.4.5 Summary

An examination of the coping literature highlights difficulties and divergences in understanding at a number of levels, from definitions to measurement. A level of agreement can be established at the level of basic definition with coping best being viewed as behaviours, overt or covert, that occur in response to a stressor, and are aimed at either directly modifying the stressor or reducing the impact it has.

At the level of determining whether coping behaviours are best described as relatively consistent behavioural patterns representative of personality constructs, or as behavioural responses that are context and stressor specific remains an area of debate. This debate as to the nature of coping behaviours has clear implications for the design of research tools that attempt to measure coping. A degree of synthesis

between the coping as personality, and the coping as process schools of thought has emerged within the coping literature in recent years leading to the development of a model of coping that takes cogniscence both of dispositional and contextual factors (Suls *et al.* 1996; Suls and David, 1996; Lazarus, 2000). However, such a model is rarely applied in research (Coyne and Racioppo, 2000), and, although flawed, checklists tailored to either one traditonal model or the other are still the most commonly used measures of coping (Coyne and Gottleib, 1996).

At the level of conceptualising the dimensions upon which coping should be measured, any coming together of the current disparate views is absent in the literature. As Suls *et al.* (1996) state;

> "Despite many years of theory and research and the development of a variety of self-reporting coping instruments, researchers still do not have a comprehensive understanding of the structure of coping." (Suls *et al.*, 1996, p 721).

In other words,

> "The structure of coping and the best way to measure it remain unresolved." (Suls *et al.*, 1996, p 723).

The most common dimensions used in the published literature remain Lazarus and Folkman's emotion focused and problem focused dimensions (Parker and Endler, 1992), whereas more recent formulations have suggested that all coping is essentially emotion focused (Cox and Ferguson, 1991; Dewe *et al.*, 1993). It does however, seem possible to maintain the dimensions of emotion and problem focused within this more recent formulation if both are assumed to be attempt to reduce the emotional consequences of a stressor, with emotion focused coping behaviours being those aimed directly at those consequences, and problem focused being those behaviours aimed directly at the stressor, and indirectly at the consequences.

Within this project coping is viewed, in line with Lazarus' (2000) recommendation, as occuring within a transactional model of the stress process. It will be defined as behaviours that are employed by an individual to deal with stressors either by direct action on the stressor (problem focused), or by modification of its consequences (emotion focused) while taking account of the notion that all coping behaviour attempts to modify the emotional consequences of a stressor. Although not ideal, measurement will be made through a checklist that asks for coping behaviours in response to a specific stressor, but it will be assumed that the answers given are likely to be as representative of underlying personality organisations as they are of specific behaviour patterns.

As discussed previously, the presence of resources that an individual may draw upon in the face of stressors is a key component of the transactional model of stress. The next two sections will examine the resources under investigation within this project; those of social and professional support.

1.5 Social Support

1.5.1 Background and Definitions

In the mid-1970's, several papers presented the thesis that social and environmental variables were important risk factors in the aetiology of psychological disorders. In particular it was suggested by some that social support and interpersonal relationships could protect individuals from the negative effects of stressors (e.g. Caplan, 1974; Cassel, 1976; Cobb, 1976). Such predictions generated much research into social supports in psychopathology. Initially, the study of social support was derived from public and epidemiological health models of disease that were applied to psychological phenomena. A key concept in these models was *multifactorial*

causation (Price, 1974), where aetiology was seen as a result of multiple interacting risk factors, and social support was seen to be an appropriate representative of the psychosocial assets or resources of an individual. The idea of social supports as protective was a major shift from pre-1970's thinking which had typically viewed social environments as a set of demands to which the individual had to respond, accommodate, or compromise in response to (Heller, 1979). The papers of the mid 1970's were pivotal in turning attention to the protective value of social support to an individual facing a stressor, as Cobb (1976) stated,

> "We have seen strong and often quite hard evidence, repeated over a variety of transitions in the life cycle from birth to death, that social support is protective." (Cobb, 1976, p 310).

Like stress and coping, social support can and has been defined in numerous ways. In Cobb's 1976 paper he defined social support as,

> "information belonging to one or more of the following three classes:
> 1. Information leading the subject to believe that he is cared for and loved.
> 2. Information leading the subject to believe that he is esteemed and valued.
> 3. Information leading the subject to believe that he belongs to a network of communication and mutual obligation." (Cobb, 1976, p 300).

This definition places particular emphasis on two characteristics of social support; that of the actual presence of a support system, and that of the notion of love, value, and a feeling of belong as being central components of that support system. These two aspects of social support have consequently been referred to as the *structural* and *functional* aspects of support respectively. The structural aspects of social support refer to concepts such as social integration, and size of social network. These concepts have been described in a number of ways, but can be thought of as representing, "the participation and involvement of a person in his or her social life, in the community and in society." (Laireter and Baumann, 1988, p 199). Laireter and

Baumann (1992) also point out the intimate relationship between the functional and structural aspects of social support, in that a structural aspect is a necessary pre-requisite of any functional aspects.

The functional aspects of social support are often divided broadly into the two categories of; perceptions of support, and the actual receipt of it. Such a distinction is important due to the fact that the two variables are only weakly correlated with one another, and appear to be associated with different health outcomes (Dunbar, 1995).

Researchers have made further divisions within these broad categories in an attempt to describe more completely the components of support. For example Cohen and Wills (1985) describe four types of social support that could possibly act as resources against stress. Firstly, esteem, or emotional support is when an individuals self-esteem is enhanced through communication from others that they are valued for their own worth and are accepted despite any difficulties or faults. Secondly, social companionship is that support offered through engaging in recreational and leisure pursuits, which may reduce stress through a sense of affiliation, distraction from stressors, or by promoting positive moods. Thirdly is informational support, which refers to the supply of information or advice from a social network that may facilitate coping with stressors, and finally, instrumental support or material support is the provision by others of actual resources such as finances, time, tools etc. that can be used to assist coping.

Other definitions and classifications of social support have tended to focus around the distinction between the components of emotional and practical support. For example, Heller, Swindle, and Dusenbury (1986) define social support as containing at least two factors; esteem enhancement, and stress related interpersonal aid. The

first of these is the concept of an individual having his or her self esteem enhanced through perceiving that they are recognised, respected or otherwise valued by their social support network. Such factors may not be directed towards one particular individual, but potentially to the network in general. The second factor can be thought of as direct aids to coping, i.e. the assistance that another can give to an individual at times of stress in terms of emotional, intellectual, or practical support (Heller *et al.,* 1986). Such a system of classification is prevalent in the stress literature, with social support being viewed as socioemotional, practical and informational aid provided to the individual by significant others in their life (Thoits, 1986).

In summary, social support can be thought of as describing either the structure of an individual's social support network, or the functional aspects of this network. Further divisions have been made within these aspects, particularly for the functional aspects, however, as Power, Champion and Aris (1988) report,

> "Although a large number of distinctions exist in the literature between different categories of support, these all appear to be subcategories of emotional or practical support." (Power *et al.*, 1988, p 349).

Therefore within this project social support is defined both as the structure of the social network (structural social support), and as the perceived receipt of emotional and practical support from individuals within that network (functional social support).

1.5.2 Mechanisms of Social Support

The definitions of social support carry within them an idea of how social support might operate upon an individual to effect their well being. Thoits (1986) in a paper entitled, "Social support as coping assistance", drew upon social psychological

theory in an attempt to explain the mechanisms of how and when social support works. Thoits argues that social support and coping have similarities, such as problem focused coping / practical social support, and emotion focused coping / emotional social support, such that social support can be thought of as the active participation of others in an individuals efforts at stress management. Drawing upon Lazarus and Folkman's (1984) model of stress that emphasises the threat of the stressor as a threat to the individual, and assumes that these threatening stressors can be modified by behavioural or cognitive techniques, then a 2 x 2 matrix (table 1.1) can be drawn up describing the mechanisms of social support;

	Cognitive Techniques	Behavioural Techniques
Practical Support	*Cognitive - Practical* e.g. reappraisal from others through, anecdotes, advice, experiences etc.	*Behavioural - Practical* e.g. changing the situation, removing the situation, or person from it.
Emotional Support	*Cognitive - Emotional* e.g. focusing on internal states, sharing of similar emotional experiences.	*Behavioural - Emotional* e.g. supplying food and drink, drugs etc., physical closeness.

Table 1.1 Thoits' (1986) matrix of social support as coping assistance

Thoits argues that the provision of social support (or coping assistance as she terms it) can not be given by just anyone, and effective support is most likely to come from those who have faced or are facing a similar stressor, and have done so, or are currently doing so more calmly. Both sociocultural and situational similarity enhance the likelihood of empathic understanding between supporter and supported, the condition under which Thoits suggests coping assistance is most likely to be effective. Thoits draws upon social comparison theory, that suggests effective support matches the needs and values of the distressed individual, and that empathic understanding may be the key to that match. The perception of this by the stressed

individual will be key in their seeking, accepting and finding helpful, coping assistance (Thoits 1986; Heller *et al.,* 1986). Thoits' conceptualisation suggests that social support acts as assistance to an individual, and as such buffers the potential negative effects of a stressor. This buffering model of social support can be represented as follows;

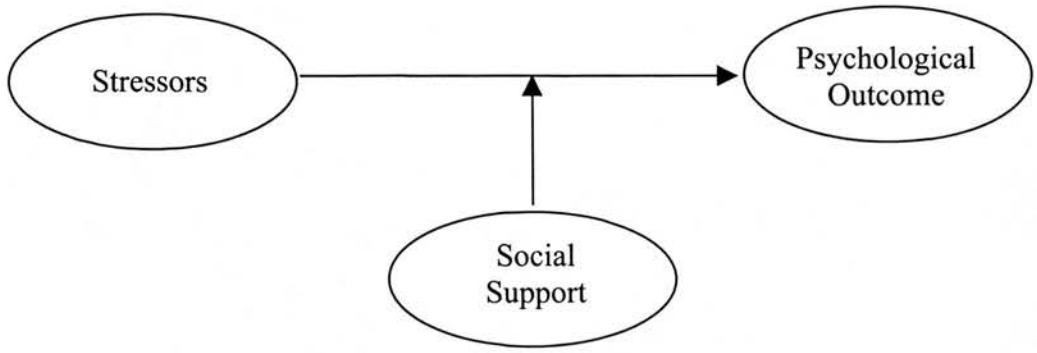


Figure 1.8 Social support as a buffer to stressors

As well as providing a buffering effect against stressors, social support has also been conceptualised as having a direct effect on well being through a variety of mechanisms. Cohen and Wills (1985) describe how social support may provide a direct effect on well being by providing the individual with consistent and frequent positive experiences with other people, and a feeling of belong within a system. In an effort to examine the extent to which both the buffering hypothesis and the direct effect hypothesis best explained the mechanism of social support Cohen and Wills (1985) carried out a comprehensive review of the stress and social support literature. They found that within the reviewed studies there was evidence for social support acting both as a direct effect and as a buffering effect in the maintenance of well being, in a non-exclusive fashion. The model of social support having a direct effect on well-being can be represented as follows;

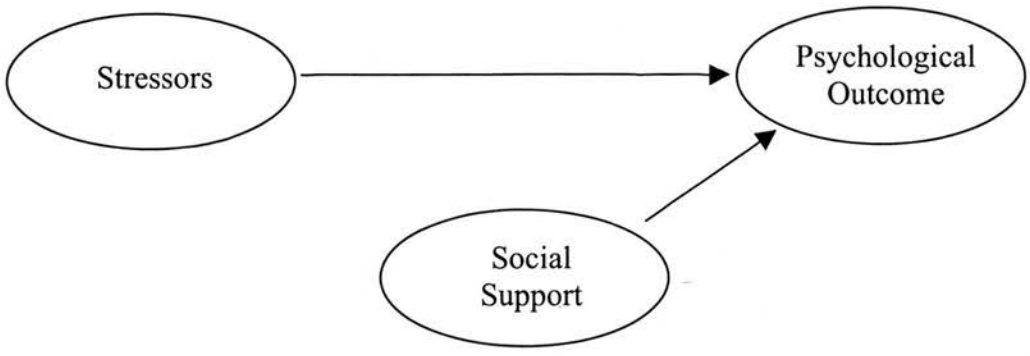


Figure 1.9 The direct effect model of social support

In their discussion of these findings they stress the importance of a matching between the kind of social support on offer, and that required by the individual in determining the effectiveness of the support. This, 'matching hypothesis' essentially states that positive outcome will depend upon the right kind of support, being given by the right kind of person matching the specific stressor being experienced.

Support for the direct effects of social support has also been obtained in longitudinal studies, which eliminate some of the difficulties inherent in cross sectional social support research, such as that of being unable to determine causality (Monroe, Bromet, Connell, and Steiner, 1986). Monroe *et al.* (1986) report data from a longitudinal study aimed at testing the hypotheses that social support and life events predict depressive symptomatology, either independently (direct) or interactively (buffer). They found that measured life events and social support acted independently of one another supporting the model of direct effect over a buffering effect.

However, a recent longitudinal study by Frese (1999) found evidence for buffering effects of social support, and in particular described findings suggesting that social

support had a greater buffering effect against social forms of stressor. They found that social support had the largest effect upon social anxiety and irritation, and not upon psychosomatic complaints and depression. They conclude that social support acts in a buffering way, and to a greater degree for stressors falling within the social arena. This finding has found more recent support in an experimental study by Horowitz *et al.* (2001), in which social support was provided by one group, and received and rated by another. The type of support requested and given were manipulated such that there was either a request-support match or discrepancy. They found that the receivers of the support were more satisfied with the support when it matched the nature of the request they had made. Horowitz *et al.* (2001) conclude that the supportiveness of social support is dependent upon how closely the support offered matches the goal of the request.

Viswesvaran, Snachez, and Fisher (1999) carried out a study designed to test which of the above models best describes how social support can effect the stressor-well being relationship. They carried out two meta-analyses, the first to describe the relationship between the general constructs of the stress process, and the second to examine the mechanisms by which social support might differentially operate. Their findings provided strong evidence for the direct effects of social support, that is social support having an enhancing effect on well-being independent of stressors, and some evidence for social support having a moderating (buffering) effect upon the stressor - well-being relationship. They describe the most important aspect of their study as the finding that social support can act directly and as a buffer. They further argue that social support acts in a threefold manner; Firstly to directly enhance well-being, secondly, to moderate (buffer) the effects of stressors on well-being, and

thirdly to mediate the stress - well being relationship by acting directly upon the stressor. This combination of the mechanisms of social support can be represented diagrammatically in the following way;

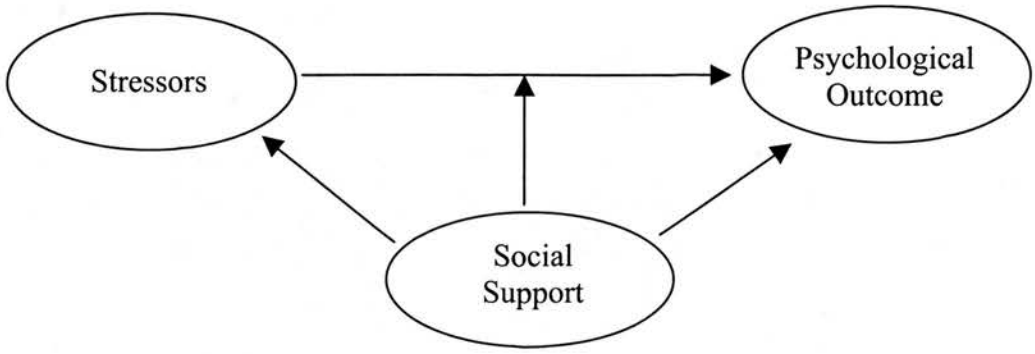


Figure 1.10 A combined model of social support mechanisms

Within their meta-analyses Viswesvaran *et al.* (1999) found no evidence for social support acting as a mediator in the stress process, nor for it being mobilized in the face of stressors.

1.5.3 Development of Social Support

The definitions of social support, and suggested mechanisms by which it operates tend to indicate little about how an individual might develop a social support network over time. A developmental perspective allows an account not only of the characteristics of an individuals social support network at any given time, but also of how an individuals psychosocial development and current characteristics impact upon the development and usage of that network. Similar to the distinction between contextual and dispositional factors in coping behaviours, an individuals social support network is likely to be dependent upon individual characteristics as well as situational ones, and those individual characteristics a product of developmental experiences. The idea of developmental factors having an influence on current social

support networks can be related to a number of different theoretical frameworks, from Kleinian ideas of personality development through early object relationships (Mitchell, 1986), to Bowlby's models of infantile attachment (Bowlby, 1969), both of which stress the importance of early caregiver relationships in the development of an individuals style of engaging in future relationships.

Brugha (1995) supports a developmental perspective arguing that above and beyond objective, quantitative, and functional definitions, social support is highly dependent on individual characteristics such as cognitive and behavioural repertoires, social and psychological development, and current mental health. For example, an individuals levels of dependency, or narcissism say, may reflect their developmental experiences, and will effect their capacity to utilise the social supports that may be available to them. Brugha suggests that the importance placed upon these factors differs greatly between different schools of thought, but that in review, there is evidence to suggest that concurrent environmental factors are no greater in their importance than constitutional or developmental factors in determining social support.

Champion (1995) describes a developmental model of social relationships which takes into account how early relationships and internal characteristics may shape the nature of any future social relationships, which in turn influence still future ones. For example, early attachment patterns having influence upon future attachment patterns. This association is not a simple one, but a study by Skolnick (1986) rating attachment patterns as positive (+) or negative (-) across the lifespan, showed the two most common paths of attachment across infancy, childhood, adolescence, and adulthood, were ++++, and ----. However the next most common was -+++,

indicating that although early attachment styles tended to be repeated across the lifespan, later relationships could sometimes modify earlier disruptions in attachment. Champion's (1995) model is represented below;

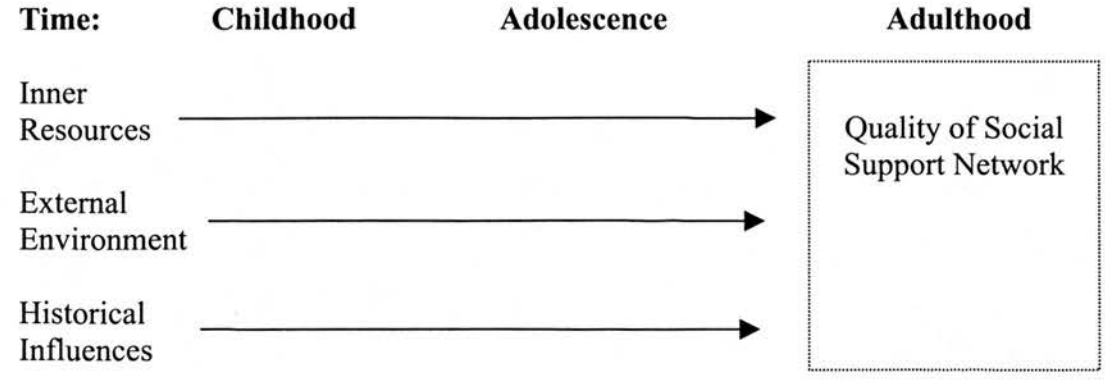


Figure 1.11 A model for conceptualising social support from a developmental perspective (Champion, 1995, p 89).

In this model the current social support network is seen to be dependent upon internal factors, external factors, and historical factors, both in the present and across the lifespan. Champion argues that such a viewpoint on social support is important in that;

> "Assessing the interaction and relative contribution of the internal and external aspects is especially important when addressing the need for intervention and whether this should be targeted mainly at manipulating the environment or altering some internal aspect of the individual." (Champion, 1995, p90).

1.5.4 Social Support as Protective to the Individual

Since the publication of Cassell's and Cobb's 1976 papers highlighted the protective aspects of social support, the literature has largely focused upon the benefits individuals gain from a network of social support. Cohen and Wills' (1985) review of the relevant literature indicated that there was considerable evidence that social support has beneficial effects on the individual both directly and in terms of

buffering the effects of stressors, and many of the definitions of social support carry within them the notion of benefit (Thoits, 1986).

More specifically the presence of social support has been suggested as a mediator between the experience of life events and depression. For example in Brown and Harris' (1978) study a lack of social support was found to be one of four major vulnerability factors in predicting the onset of depression in individuals facing a major life event. Champion (1990) also found that the presence of this social vulnerability factor was also associated with an individual experiencing more negative life events as well as elevated incidences of depression. More recent work by Lam and Power (1991) has demonstrated the continued importance of social relationships in achieving life goals. Incorporating these findings into a socio-cognitive model of depression, Champion and Power (1995) suggested that a lack of social support reduces an individuals potential roles and goals in life, and constrains the options and flexibility for engaging in self-value increasing activities.

Paykel (1995, 2001) reviewed the evidence regarding the effects of social environment on the development and maintenance of affective disorders, and found that although levels of social support are likely to be influenced by an individuals capacity to form and maintain relationships, an absence of social support is associated both with the onset and chronicity of depression. Paykel (2001) concludes that the social support literature suggests that interventions based upon increasing levels of social support around times of likely stressors may be preventative for depression. However, Brugha (1995) reports on longitudinal studies indicating that while social support levels have some predictive value for the onset of

psychopathology, they have a more consistent predictive power in terms of the course and outcome of ongoing mental health difficulties.

Lloyd (1995) comments on the large amount of research that has investigated the relationship between social support and psychological well-being. A multi causal model can be derived from this work where the aetiology of psychiatric disorder can be viewed as a dynamic process between the personality, strengths and weaknesses of an individual, the stressors to which they are exposed, and the resources such as social support upon which they can call. Lloyd (1995) argues that the social support findings should be viewed within such a framework.

1.5.5 Social Support and Physiological Processes

In 1988, House, Landis and Umberson published a review article in the journal, Science, showing that mortality was higher among socially isolated individuals, and that this relationship was comparable with standard risk factors such as smoking, blood pressure, and levels of physical activity. Following on from this and several other seminal studies such as Cassell (1976), a body of research has focused upon the physiological mechanisms underlying this association, i.e. what physiological changes does social support bring about? In a recent review Uchino, Cacioppo and Kiecolt-Glaser (1996) carried out a qualitative and meta-analytic review in this area, citing Cassell's (1976) idea that there are likely to be multiple physiological pathways by which social support influences disease states, as their starting point.

In reviewing 81 studies they found that social support was reliably related to beneficial effects on aspects of cardiovascular, endocrine, and immune systems. Such a finding has also been reported in non-human primates (Coe, 1993; Gunnar, 1992).

Importantly the systems involved play important roles in the leading causes of death in western society; cardiovascular disorders, cancer, and respiratory illnesses.

Furthermore, Uchino, Uno, and Lunstad-Holt (1999) found that stress buffering effects operated in some studies with familial sources of support, and emotional support in particular appeared to be the most important aspects of social support. Such evidence lends further support to the idea of social support having beneficial consequences for the individual.

1.5.6 Social Support as Detrimental to the Individual

Running parallel to the literature providing evidence for the protective nature of social support is a literature pointing both to the weaknesses in the associations demonstrated (Dohrenwend and Dohrenwend, 1981), and suggesting that high levels of social support can also be associated with low levels of well being (Schwarzer and Leppin, 1991). Buunk and Hoorens (1992) presented four different models of social support in an effort to describe the often paradoxical effects seen in the social support literature, and make a distinction between the *perception* that one can turn to others in the social network for support, and the actual receiving of support from others once a stressor has occurred, that is *actual* enacted support. They present social comparison theory (comparing self with others as a way of coping and/or self enhancing), and social exchange theory (negative affective reaction occur when the desired equity of a particular social relationship is disturbed) as a way of explaining negative findings. They suggest that the negative direct effect of social support may arise through an unfavourable social comparison with those providing support, leading to increased polarisation, and increased beliefs about ones own inefficacy. Social exchange theory suggests that an inequity may arise through provision of

social support that is perceived as negative by the recipient. Buunk and Hoorens (1992) conclude their article by stating,,

> "Neither does the present article deny the positive direct and buffer effects of social support that are often obtained, nor is it meant to suggests that social support is generally not available in situations where it is highly desirable and to individuals who are in special need of it. The point made here is that the beneficial effects and the automatic presence of social support should not be taken for granted." (Buunk and Hoorens, 1992, p 454).

In a more recent study Dunbar, Ford and Hunt (1998) report on the finding that psychological distress is associated with increased levels of social support, when the social support measured is the *actual receipt* of social support, rather than an individual's perception. They describe three potential hypotheses to explain these association. The first of these states that the associations are spurious and a product of stressors increasing both level of social support and psychopathology (Support mobilisation). The other two argue that receiving support actually causes distress. In the first of these, the negative outcome is a product of inequity in the social relationship (inequity hypothesis), and in the second the effect is viewed as arising from support bringing about a threat to an individuals esteem and thus causing distress. In a study using individuals with a reported disability, and those without a positive correlation was demonstrated between levels of social support and anxiety, but not depression. This was removed when sex was controlled in a non-disabled population, but in a disabled population the association was best explained by the inequity hypothesis. That is social support brought about increased anxiety in the disabled individuals due to it being perceived as representing an inequity in relationships.

1.5.7 Summary

In summary, social support has been variably defined, but running through these definitions are categories of functional and structural aspects of support, with the functional aspects being further defined as being, in general, either of an emotional or practical nature. The exact mechanisms by which social support operates is an area of ongoing debate, with findings being at least in part dependent upon the type of social support under examination. Various studies have shown social support to act directly on the individual (direct effect), as an aid to the individual in coping with a stressor (moderating / buffer effect), and to a lesser degree, directly upon stressors (mediating effect).

There is a large amount of evidence suggesting that the perception of social support is associated with well being, both psychologically and physiologically. However in contrast to this, there is a body of evidence suggesting that high levels of actual social support are associated with poor health outcomes. Such mixed findings highlight the need for clear definitions within studies.

Coyne and Downey (1991) report on the place social support might have in the stress process relationship, pointing out how difficult it is to disentangle social support from life stressors in that they are both a reflection of an individual existing within a complex developmental, interpersonal and environmental matrix that is multidirectionally interacting. For example an individual may always develop maladaptive relationships and as a result suffer as a result of those relationships, whereas for another, the presence of very few relationships is supporting and beneficial, while for still another the large supportive network they have may be experienced as overwhelming and belittling. It is the nature of the support network,

the nature of the individual and the nature of the context, and how all these three interact that will ultimately predict outcome. As Coyne and Downey (1991) state,

> "Here we challenge the very identity of key variables in the stress process. Seemingly independent life events may be markers for other current adversities, or they may be the direct and indirect results of past experiences, including childhood adversity and victimisation, previous episodes of psychopathology, and mate selection. Perceived support may often best be viewed as the absence of particular kinds of adversity in interpersonal relationships, and these adversities might just as well be seen as strains or chronic stressors." (Coyne and Downey, 1991, p 420).

As with the literature on coping and stress in general, such a statement emphasises the complex interplay of environmental, situational, personal, and developmental aspects in the conceptualisation of social support as one of the components in the stress process.

1.6 Professional Support

1.6.1 Definitions

The literature examining support at work has largely drawn upon the social support literature as a frame of reference, and indeed many studies refer to the concept as work-related social support (Dormann and Zapf, 1999; Frese, 1999; Beehr, 1995). As such, the definitions, mechanisms and issues related to work-related social support, or professional support as it will be referred to in this study, can be thought of as analogous to those described in the previous section (e.g. Dormann and Zapf, 1999).

In the field of psychological healthcare, very little work has been carried out examining the relationships between general levels of professional support and outcome (Maslach, Schaufeli, and Leiter, 2001), with the few published studies showing both main and moderating beneficial effects of professional support (Dormann and Zapf, 1999; Frese, 1999; Maslach *et al.,* 2001). Despite this dearth of general literature, there does exist a body of work focussing on two particular

sources of professional support relevant to practitioners of clinical psychology and psychotherapy. The first of these is supervision, which is commonly defined as a dyadic relationship in which one person helps another to modify behaviours, affects and cognitions so as to enhance the service being provided under the supervisees care (Hess, 1980). The second of these is personal therapy, which within the literature refers to the experiencing of a personal psychotherapy by the clinician.

1.6.2 Supervision

Supervision is widely regarded as the most commonly used method of training in clinical psychology and psychotherapy (Binder, 1993). Despite this there is a lack of literature relating to the effectiveness of supervisory procedures or their comparative efficacy (Halgin and Murphy, 1995), and the few studies that have been published, have been of poor design and execution (Ellis, Ladany, Krengel, and Schult, 1996), and show that the results of supervision are by no means unequivocal (Binder, 1993). Theoretical models of the supervision process are in abundance however. For example Ekstein and Wallace's (1972) model of supervision as a parallel process, where transference / countertransference patterns operating within treatment are re-enacted within the supervisory relationship, allowing the supervisor to use his or her clinical skills to make reference to the dynamics occurring in the treatment relationship. This model has a lot of credence within psychodynamic schools, but there is no empirical evidence for its validity either in theory or in practice.

Developmental models such as that proposed by Glidden and Tracey (1992), forward the idea that a trainee's development from novice to more experienced therapist is characterised by a sequence of stages, with the supervisors behaviour adapting to meet the needs of the trainee at each stage.

In summarising the overall purpose of supervision Stricker (1988) states that,

> "(1) the patient's needs should be paramount in the therapeutic situation, (2) the therapist's interventions should be tailored to meeting these needs, and (3) the supervisor's role is to facilitate the occurrence of the firsts two conditions." (Stricker, 1988, p180).

As Guy (1987) describes, the supervisor's role is multifaceted, being one of teacher, facilitator, and evaluator. Within these roles the supervisor has to balance the needs of patient and supervisee in order to provide, 'good supervision'.

The concept of good supervision has received much commentary, but little empirical investigation. A review by Carifio and Hess (1987) of the supervision literature concluded that an ideal supervisor has personal qualities of empathy, respect, genuineness, flexibility, concern, investment and openness. They further suggested that good supervisors have the ability to use appropriate teaching and feedback techniques, whilst maintaining a supportive, non-critical, and respectful position. Halgin and Murphy (1995) point out that, like good psychotherapy, the heart of effective supervision is a collaborative working relationship, and that a good supervisor is one who can tailor the support and information they give to the needs and learning style of the supervisee. Drawing further comparison with psychotherapy, Halgin and Murphy (1995) describe how a variety of methods can be employed in the provision of supervision. For example a novice trainee will require different elements than a highly experienced clinician, and as such the context of supervisee, supervisor, setting, goals, and needs of the patient will determine the most appropriate methods. Watkins (1990) suggests that development as a good supervisor is at least as difficult an achievement as the development of therapeutic competence, yet supervisory skills are often treated as if they develop automatically

without the need for specialist training, or a coherent model or approach (Binder, 1993).

In an attempt to acquire some empirical evidence to support the many models of supervision, McCarthy, Kulakowski, and Kenfield (1994) surveyed practising psychologists as to their experience of providing supervision. They found that of reported roles, consultant (40%), teacher (20%), evaluator (17%), administrator (12%), and counsellor/therapist (5%), were the most frequent. Goals of the supervisor included adherence to ethical standards, improve supervisee skills, facilitate personal growth, and satisfy own professional needs. The techniques most frequently reported were support, open ended questions, information giving, advice and reflection of content and feelings. In a similar study looking at psychotherapists and counsellors experiences of supervision, Arnott, Dorkins, and Aylard (1996) found that the foci of supervision could be grouped in to the six areas of the therapeutic relationship, interventions made, parallel process, therapist countertransference, supervisor countertransference, and verbatim accounts of therapy.

Milne (1998) reports on the use of supervision by clinical psychologists in the NHS at a time when pressure is being placed upon the profession to be time effective and show an evidence base for their practice. He argues that in clinical psychology there is a common consensus that supervision is a way of assuring quality and assuring competence (Miller, 1990), as well as being emphasized by the British Psychological Society and the Division of Clinical Psychology as a way of regulating, maintaining and developing effective clinical practice at all levels of professional functioning (BPS, 1991; BPS, 1995a). However in terms of an evidence base for supervision,

Milne suggests it is at best weak, and argues for increased emphasis upon the training, evaluation and provision of supervision, given its central role in the development of clinicians. In a similar vein, Rodolfa, Haynes, Kaplan, Chamberlain, Goh, Marquis, and McBride (1998) report that there were no significant differences in supervision practice between short and long qualified psychologists, with all groups reporting it a low priority in their professional work. Furthermore all groups report a general absence of training in supervision on their training courses. Rodolfa *et al.* (1998) suggest that training in supervision should be an integral aspect of doctoral training in clinical psychology.

In summary, the various models and proposed mechanisms of supervision suggest that it is a potentially rich source of practical and, perhaps to a lesser degree, emotional support for a clinician. However despite this, it has received little empirical research, appears to be low on the priority list for clinical practice, and is absent from the syllabus for training courses in clinical psychology (Milne, 1998).

1.6.3 Personal Therapy

Since the publication of articles such as Eysenck's 1952 review paper that questioned the effectiveness of psychotherapy (Eysenck, 1952), there has been an exponential rise in psychotherapy outcome literature, the aggregate findings of which point to; an overall efficacy for psychotherapy when compared with control treatments (Lambert and Bergin, 1994; Roth and Fonagy, 1996), specific psychotherapeutic treatment efficacies (DeRubeis and Crits-Christoph, 1998), an equivalence in efficacy between different types of psychotherapy (Wampold, Mondin, Moody, Stich, Benson, and Hyun-nie, 1997), and more recently, a measurable clinical effectiveness of specific psychotherapies (Chiesa and Fonagy, 1999; IPA, 1999).

In contrast to this voluminous literature demonstrating the beneficial effects of psychotherapy among clinical populations, the literature regarding the effects of personal therapy for clinicians is relatively meagre and inconsistent (MacCaskill, 1999).

The tradition of personal therapy for would be psychological therapists is an old one and is often traced back to Freud's 1937 paper on psychoanalysis (Freud, 1937) where he states;

> "But where and how is the poor wretch to require the ideal qualifications which he will need in his profession? The answer is in an analysis of himself." (Freud, 1937, p 56).

More recently, MacCaskill (1988) provides an outline of the rationale for personal therapy for therapists. The central ideas suggested by MacCaskill are that the therapist needs to have an intimate understanding of himself and be aware of her own conflicts and responses to others, such that they do not intrude unnecessarily upon therapeutic work with the patient. A second purpose suggested by MacCaskill is that of gaining a genuine experience of therapy such that genuine empathy will exist with future patients. Macran and Shapiro (1998) extend these reasons adding that personal therapy can also serve to alleviate some of the stressors and strains inherent in practicing therapy, directly enhance emotional and mental well-being, provide a direct teaching experience, and increase therapist conviction about the work they carry out - a factor that has been shown to be important in therapeutic outcome (Bergin and Garfield, 1994).

In a review of the fifteen locatable studies investigating the effects of personal therapy, MacCaskill (1988) found that between 66% and 84% of therapists were satisfied with their therapy. Only one study reviewed, that of Buckley, Karasu, and

Charles (1981), gave details of therapy outcomes, showing that 94% of the surveyed sample reported improvements in self esteem, 86% improved work function, 86% improvements in social and personal life, 89% characterological changes, and 73% symptomatic improvements. Norcross (1990) advances the idea of personal therapy as a protective factor against stress in psychological therapists, finding that over 50% of his sample sought personal therapy post-qualification, and that of this population over 92% reported considerable benefit from the experience. In a more recent British study, MacCaskill and MacCaskill (1992) surveyed all senior registrars in psychotherapy about their experience of personal therapy. They found that 91% of the group reported purely positive outcomes of their therapy, with moderate to very positive effects on both personal and professional life. The most commonly cited effects of therapy were increased self esteem, increased work competence, symptom reduction, and improved personal relationships. A similar finding was reported by Pope and Tabachnick (1994) who surveyed psychotherapists to investigate their experiences of personal therapy. They found that 84% of the respondents had experienced personal therapy at one time or another, with the primary reasons for attendance being depression or unhappiness, marriage or divorce, relationship difficulties, low self esteem or self confidence, and anxiety problems. Of the group that had experienced personal therapy 85.7% reported finding it very or exceptionally helpful. When asked about the aspects of therapy they had found helpful, increased self awareness or self understanding, increased self esteem or self confidence, and improvement of own therapy skills were the most common responses. Pope and Tabachnick remark on the finding that depression was the most common reason for attendance at therapy, and suggest that training courses prepare

trainees for the possibility that they may experience some form of depressive episode at some time in their careers. Within the UK, Darongkamas, Burton and Cushway (1994) found that 41% of clinical psychologists surveyed had experienced personal therapy, and that around 80% of those reported having found the experience beneficial for their personal and professional lives.

The small amount of evidence available therefore, would suggest that personal therapy has beneficial outcomes for its recipients, however the research looking at how experience of personal therapy ultimately impacts upon patient treatment is less clear. For example, Clark (1986) reviewed the available empirical research and found no evidence for any beneficial impact upon the delivery of therapy, but Clark suggested that the research was in its infancy and had failed to look at factors like the personal characteristics of the clinicians entering therapy. In a more recent review Beutler, Machadoo, and Allstetter Neufeldt (1994) reported that although therapist adjustment level has been shown to relate to good treatment outcomes, there is no conclusive evidence for or against an experience of personal therapy relating to good outcome in clients. They suggest that an association does not exist between receipt of personal therapy and patient outcome, because studies so far have failed to take into account the variance in personal characteristics and motives of the clinicians entering therapy. As Sinason (1999) suggests, there are some individuals who will gain from personal treatment, others who will have a positive effect on their patients independent of how much therapy they have experienced, and still others who even after lengthy analysis will fail to deal with certain problems.

In reviewing the personal therapy literature, Macran and Shapiro (1998) conclude that although the evidence base is small, some consistent findings emerge. These are

that, most therapists report their experience of therapy as personally and occupationally beneficial, therapy increases therapeutic activity and awareness of transference / countertransference issues, and that although there is little evidence for a direct effect of personal therapy on client outcome, there is evidence that receipt of personal therapy enhances skills necessary for therapeutic change such as warmth, empathy and genuineness. Such consistencies have led researchers such as Halgin and Murphy (1995) to suggest that despite the lack of empirical evidence for effects upon clinical practice, personal therapy should still be viewed as an important resource for those working in the field of therapy, for educational, supportive, and personal reasons.

1.6.4 Summary

Viewed within the definitions and models of the more prevalent social support literature, professional support can be conceptualised simply as work-related social support. An examination of two potential sources of this support for clinical psychologists suggests that both supervision and personal therapy can provide both the emotional and practical aspects of support described in the previous section.

Supervision could be hypothesised as operating primarily as a moderator in any stress process occurring in clinical work, by the provision of practical information and techniques to enhance the supervisee's ability to cope. Personal therapy on the other hand can be argued to operate primarily in a direct way, giving emotional support to the individual. The literature does suggest however that both supervision and personal therapy could both be potential sources of emotional and practical support to their recipients.

1.7 Research Review

1.7.1 Background

Most jobs contain stressors of some form or another, however it has been argued that those employed in the field of healthcare are exposed to stressors above and beyond many other jobs due to a variety of reasons. For example, Maslach (1982) identified working directly with people who are experiencing emotional difficulties as one of the most important antecedents of job burnout. Burnout, according to Maslach, is represented by the three core areas of emotional exhaustion, depersonalisation, and reduced personal accomplishment, occurring in response to the chronic emotional strains of dealing with others who are experiencing difficulties. As such it can be thought of as a specific description of an internal state of reduced well being brought about by work related stressors

Intrinsic to work in most organisations are the stressors of job pressures, role overload, role conflict, and role ambiguity, that are in turn related to the emotional and practical consequences of stress (Moore and Cooper, 1996). Such pressures are prevalent in health workers, for example Shinn, Rosario, Morch, and Chestnut (1984) found that poor job design was the most frequently reported stressor at work amongst a sample of mental health workers. This included heavy workloads, role conflict, and a variety of other work conditions. However, Rees and Cooper (1992) reported that health care workers experienced more stress from the organisational structure when compared with administrative staff, and that healthcare workers experience of stress was greater than that of blue and white collar non-health workers.

Moore and Cooper (1996) reviewed the sources of stress in mental health professionals and suggested that a major factor relates to the discrepancy between

worker expectations of change, and experienced change in clients. Such a discrepancy challenges the esteem of the worker, and their sense of self efficacy. Such a theme is supported by higher experiences of stress amongst those workers working with longer standing mental health problems. As a result of their review Moore and Cooper (1996) proposed an interactive model of stress incorporating, personality, work, and home. They report that single workers report less stress than married workers, but also suggest that marriage may also act as a buffer, dependent on the quality and nature of the marital relationship. They also report that level of training is related to increased job dissatisfaction, and suggest this may be a result of expectations increasing as training increases, and as such the scope for a discrepancy between the idealised and real work situations increases. They also comment upon the interaction between work and home, and suggest that work stresses and home stresses may interact and effect one another, and as such an examination of both is required in studies.

Prosser, Johnson, Kuipers, Szmukler, Bebbington, and Thornicroft (1997) examined sources of stress among 121 hospital and community health workers, in an effort to identify stressors and develop burnout prevention. They carried out a cross sectional survey and found that the most common sources of stress included poor role definition, poor support, impact of clients, and work overload. These factors combined accounted for 70% of the variance in measured burnout.

Maslach, Schaufeli, and Leiter (2001) provide recent support for the idea that those working in human services and health care are exposed both to the normal stressors of work, and to the additional emotional and interpersonal stressors that arise from providing aid and service to people in need. In line with more general models of

stress, Maslach *et al.* (2001) pick out the most salient aspects of burnout research as having,

> "..... its roots in care-giving and service occupations, in which the core of the job was the relationship between provider and recipient. This interpersonal aspect meant that, from the beginning, burnout was studied not so much as an individual stress response, but in terms of an individual's relational transactions in the workplace." (Maslach *et al.*, 2001, p 400).

Maslach *et al.* (2001) describe the current position on burnout as involving the study of situational characteristics, such as job characteristics, and organisational characteristics, and individual factors such as demographics and personality. They further suggest that six areas of work life come together to make up the interacting matrix of burnout antecedents; workload, control, reward, community, fairness, and values. In a similar vein to Cohen and Wills' (1985) matching hypothesis, Maslach and her colleagues propose a general model of burnout that,

> ".....focuses on the degree of match, or mismatch, between the person and the six domains of his or her job environment. The greater the gap, or mismatch, between the person and the job, the greater the likelihood of burnout; conversely, the greater the match (or fit), the greater the likelihood of engagement with work." (Maslach *et al.*, 2001, p413).

Within the twenty five years of research reviewed by Maslach *et al.* (2001), there is clear evidence that those working within the health and caring professions, such as clinical psychologists, experience a greater degree of burnout than those in non human service work (Maslach *et al.*, 2001; Schaufeli and Enzmann, 1998).

1.7.2 A Profession at Risk ?

Although little research exists on the particular type of individual who enters the profession of clinical psychology and the range of motivations behind such a choice of career, there is a body of literature that has suggested that individuals who work

within the psychotherapeutic field are particularly at risk of experiencing stress related difficulties.

It has been suggested that people are drawn to psychotherapeutic professions for a number of laudable reasons such as a natural inquisitiveness (Guy, 1987), a desire to discover the intricacies of human behaviour (Marston, 1984), and presumably of primary importance, a desire to help people and promote their personal growth (Farber and Heifitz, 1981). In addition to these motives it has been suggested that some may have motivations that are more complex and problematic. For example some are drawn to the work through a voyeuristic impulse that is satisfied by hearing about others' private lives and fantasies, whereas others are narcissistically attracted to a position of power and control where they are perceived to be omnipotent and influential (Guy, 1987, Guy and Liaboe, 1985). It has further been suggested that many are drawn to the psychotherapies as a way of resolving their own personal problems. Elliot and Guy (1993) refer to this position as one of the, 'wounded healer', literally being drawn to a healing profession in the hope of being healed oneself. Supporting this point of view is evidence showing that when compared with non-psychotherapist controls, psychotherapists have more serious dysfunction, such as abuse, divorce, and neglect, and more losses, such as parent death, and in general view their family background as less healthy and themselves as having played a more caretaking role within it (Guy, 1987; Elliot and Guy, 1993; Halgin and Murphy, 1995). As Halgin and Murphy (1995) suggest;

> "For many psychotherapists, early life experiences and family roles form a general template for their work as psychotherapists. Presumably, individuals with troubled life experiences are choosing a career that is harmonious with their psychological needs and are even selecting therapeutic approaches that may serve some curative role for their personal scars." (Halgin and Murphy, 1995, p 440).

In addition to these issues, the individual working psychotherapeutically is also exposed to the particular anxieties relating to; failure at their work (Norcross, 1988), understanding human experience, behaviour and emotion in themselves and in their patients, and the sense of being an impostor or having too many unrealistic expectations placed upon them (Guy, 1987).

Furthermore, Nichols (1988), pointing out the role psychologists often play in the diagnosis and treatment of stress in allied and other professions, discusses the relative neglect clinical psychologist's place upon managing their own stress levels, and indeed in building appropriate methods of stress recognition and management into their training programs. In short,

> "..clinical and other applied psychologists in the UK lack training and professionalism in the knowledge and *discipline* of self care." (Nichols, 1988, p50).

As such, Nichols argues, psychologists are poor role models for good self care, and run a particularly high risk of encountering high levels of psychological and physical ill health as a result of our work. He suggests that the root of this paradox lies in the training courses of applied psychology which he believes fail to promote the preventive approach in self-care, and that this is then carried through into clinical environments where little or no emphasis is placed upon support systems for the active clinicians. Nichols also highlights the absence of self-care procedures in the applied psychology literature, where various clinical approaches are discussed with no reference to the steps any psychologist should be taking for their own self care if carrying out the described work.

Nichols goes on to argue that skills in seeking and receiving support should be an integral part of both training and post training experiences, and suggests that

psychologists and psychology departments who fail to build in self-care procedures as part of the normal work load, should be seen as being guilty of psychological neglect.

In a more recent paper, Walsh and Cormack (1994) suggest that clinical psychologists may be particularly at risk, not only as a result of the work that they do, but also due to the environment (in Walsh and Cormack's paper, the NHS) they work within. They argue that although it has been shown that support from peers and supervisors moderates work stress, little effort has been put into investigating psychologists access of any available support, and what individual, professional and organisational factors mediate that access. They carried out a study that attempted to investigate these factors within a group of 94 qualified clinical psychologists. Using their findings they describe a model of support access that accounts for organisational, professional, professional-personal split, and gate-keeping factors. At the organisational level, the NHS demands productivity, efficiency, and imposes pressures on its employees to meet those demands. Such a pressure means that activities seen as not directly productive, or time efficient, such as support are not of a high priority. Professionally Walsh and McCormack suggest that expression of personal needs may be construed by the profession as suggesting the individual concerned is emotional and out of control, labels which are at odds with the widely held ideal. A professional and personal split can happen both internally, and externally between self and profession, in both cases the need being one of maintaining a persona of coping and ability, to which the expression of emotional needs is in conflict. Finally, the decision to seek support will be influenced by support availability, a variable which is clearly effected detrimentally by the above

factors. Walsh and Cormack (1994) conclude their study by pointing out the potential risks for the clinicians mental health, and the work they do that may arise from a situation where a profession that claims expertise in providing care for others is so neglectful of itself.

The lack of availability of specific treatment packages for distressed psychologists has also been cited as a factor placing the profession at particular risk. For example, Laliotis and Grayson (1985) reported on the findings of regarding the availability of treatment systems for distressed psychologists provided by the psychological associations of 51 states of America. Out of all the states surveyed, all replied and not one had a program established for treatment of psychologists, and only eight had plans to introduce one in the near future. This finding was in marked contrast to the psychological boards of each state who had clear guidelines regarding due process for the dismissal of psychologists operating in an impaired fashion. Laliotis and Grayson (1985) comment on the paradox of a lack of services to treat distress in a profession that is trained to treat distress in others, and suggest denial, the newness of the problem, and the sheer lack of numbers in the profession, as some of the factors maintaining such a situation.

As stated before, in the United Kingdom the British Psychological Society is clear about the duties clinical psychologists have in safeguarding fitness to practice outlining aspects of self care, risk reduction, and amelioration of difficulties within its professional practice guidelines (BPS, 1995a). Of particular salience within these guidelines are the concepts of distress recognition and treatment, for example;

> "Psychologists need to recognise that the demands of clinical work interact with their own personalities and that it is important that any consequent stresses are accepted as normal and understandable. They have a duty to address issues of stress and burn out, and to ensure that stress management and personal support are drawn upon to maintain optimum functioning over their professional lives." (BPS, 1995a, p30).

What is less clear within the guidelines is what the profession itself has to offer the distressed psychologist. Instead the guidelines place emphasis upon the distressed psychologist and their local organisation to seek and provide help,

> "Clinical psychologists who are experiencing high levels of personal distress because of either home-based or work-related difficulties, or both, have a duty to seek support and guidance to explore ways to resolve distress appropriately, if their fitness to practice is being impaired.....Support could take a variety of forms including provision of therapy, personal support and supervision inside or outside the organisation." (BPS, 1995a, p 31-32).

A recent request by Kapur (2000) in, 'The Psychologist' asking for members of the BPS for information regarding services that were available for helping members in distress attracted no responses in a period of six months (Kapur, 2001). This lack of provision combined with the above factors has led prominent researchers in the field such as Cushway, Watson, and Appleby (1998) to suggest that;

> "...clinical psychologists are as likely as most, and maybe more likely than some, to experience psychological difficulties themselves. Unfortunately, they may be less likely than some to be able to access appropriate help when they are in difficulty." (Cushway *et al.*, 1998, p18).

Cushway *et al.* (1998) also describe how psychologists who live and work within a defined geographical area and have close personal and professional ties with psychologists who cover their home area, are often in a position where they are unable to access a discreet and unconnected treatment service. In a groundbreaking project Cushway *et al.* (1998) describe a confidential therapy network for clinical psychologists in a region of England. Within a twelve month period the scheme

offered help to eleven psychologists (out of a total of 360 working in the area), providing some evidence that such a system is both required and used.

1.7.3 Research on Psychologists and Psychotherapists

A number of, predominantly American, studies have investigated levels of distress amongst practicing psychologists and psychotherapists in general, without a specific focus on clinical psychologists.

In some of the earliest published studies Farber and Heifitz (1981, 1982) investigated patterns of satisfactions and stressors in psychotherapeutic work. They found that between 2% and 6% of psychotherapists were burnt out. They found psychotherapists reported satisfaction in bringing about change, intimate involvement with patients lives, and being respected, and stressful aspects as arising from pressures of the therapeutic relationship, client's stressful behaviours, and difficult working conditions. Farber and Heifitz (1982) suggest that therapists expect their work to be demanding, but that this is counterbalanced by its rewards. They suggest that distress occurs when there is a discrepancy in this balance, or in other words a discrepancy between what the therapist is putting into their work and what they are getting from it.

In a similar study Thoreson, Miller, and Krauskopf (1989) point out the centrality of the Socratic imperative, 'know thyself', to many schools of psychotherapy, and how a therapist's mental health is inextricably linked with their professional functioning. Pointing to the lack of data regarding distress levels amongst practicing psychologists they report a study investigating the prevalence and type of distress, and any factors that may be predictive of that distress amongst psychologists. They found that while the majority of their surveyed sample reported good overall

interpersonal, intrapersonal, and physical health, around 10% experienced frequent levels of distress in the areas of depression, relationships, physical illness, substance abuse, and feelings of loneliness. They found that, as in the general population, women psychologists reported more depression and more interpersonal relationship problems than their male counterparts. They concluded that distress amongst psychologists was multi-faceted with high correlations being found between specific distress areas such as depression, relationship difficulties and loneliness. Along these multi-faceted lines the authors found that distress amongst psychologists ranges from a 19% prevalence rate experiencing one area of distress, to 9% experiencing two or more areas of distress. In a national survey of psychologists practicing psychotherapy, Guy, Poelstra, and Stark (1989), investigated the prevalence of distress in this group and how this was perceived by the psychologists to effect their practice. They found that 74.3% of the sample reported having experienced stress in one of eleven work and non-work related areas such as job stress, and illness in the family. Of those respondents 36.7% felt that the distress had impacted negatively on the quality of patient care delivered by them, with 4.6% feeling that the distress had led to inadequate patient care. They found that 70% of the distressed sample chose to do something in response to their distress, with individual therapy (26.6%), and lightening case load (17.2%) being the two most prevalent methods of distress alleviation.

In a further study that use regression analysis to provide a profile of psychologists most likely to experience distress, Ackerley, Burnell, Holder, and Kurdek (1989) found that being young, over involved, having feelings of low control, and seeing many clients with a history of sexual abuse accounted for 32% of the outcome

measure variance. In another review, Farber (1990) found that in terms of who is most likely to experience distress, those who are young and work in institutional as opposed to private settings are most at risk. Farber suggests that working in institutions carries with it the likelihood of encountering more long term 'difficult' patients, as well as having to deal with interprofessional rivalries, and institutional red-tape and administration difficulties. Preventative factors cited are the feelings of helping other people, the feeling of personal growth that can come through the work, and high levels of support from other colleagues. Farber describes three types of burnout among psychologists; Firstly, the frenetic burnout, who guards against an inner emptiness by hectic activity designed to satisfy the idealistic views he holds, typically a young and inexperienced individual. Secondly, the worn out burnout who is slow, tired and has lost all enthusiasm for work, more typical of a more experienced therapist who has experienced multiple failures over a long time period. Finally, the understimulated therapist, where the stresses of work are not particularly great but neither are the rewards. In a more recent study, Coster and Schwebel (1997) focused on factors that might maintain well-being amongst psychologists. In the first of two studies, six psychologists were interviewed regarding their reasons for well-functioning. They found that ten themes emerged; Peer support, stable personal relationships, supervision, a balanced life, department or school affiliation, personal psychotherapy, education, family, an awareness of the personal costs of impairment, and coping mechanisms. Though the range of resources drawn upon for well functioning was diverse, there was a heavy emphasis placed upon relationships be they professional or personal for support and problem solving. In the second study a survey of 432 psychologists was carried out asking similar questions. The findings of

this survey matched the findings of the first study with psychologists placing relationships, personal therapy and other supportive relationships as high on their list of well-functioning maintainers. Coster and Schwebel conclude by drawing out a plan of maintaining well functioning among psychologists focusing on the areas of, interpersonal support, intrapersonal activity, professional development, and self care that they feel should be integral to the working life of any psychologist. Distress being;

> "..not primarily a deficiency in professional skills but rather of adequate coping resources to deal with stressors that overwhelm the individual. The results further suggest that well-functioning can be safeguarded by strengthening coping resources through learning opportunities for that purpose both during graduate study and over the span of the career." (Coster and Schwebel, 1997, p10).

Related to the experience of distress in psychotherapists and psychologists, is how this distress impairs the clinical work they carry out. Sherman and Thelen (1998) review the literature on the effect psychologists distress can have on both their clinical work and on the profession at large. Taking a definition of stress as being the subjective experience of discontent as manifested by anxious or depressed moods, somatic complaints, feelings of low self esteem, and feelings of confusion or helplessness (Sherman, 1996), they carried out a large scale survey of practicing psychologists on distress and impairment. They found that high correlations between levels of distress and levels of professional impairment existed, with higher numbers of work factors and life events contributing to higher distress levels. They found no evidence to support the idea that level of help seeking behaviours was associated with either high or low levels of distress amongst the surveyed group. Furthermore they found no evidence to suggest that reducing the workload of a distressed psychologist brought about any alleviation in distress levels. They conclude that it is

likely that psychologists will experience distress when faced with life events or stressful work events and that this distress will have a negative impact upon the therapeutic work done by that psychologist. They argue that distress awareness should be built in to clinical work as a matter of routine, despite the increase in pressure on clinical time that arises from certain healthcare systems. Furthermore they emphasise the centrality of the training experience both in teaching psychologists how to recognise and alleviate any distress they may experience, and that as such training courses should be proactive in preparing trainees for the eventuality of distress. Sherman and Thelen (1998), also make recommendations for organisations and for the profession as a whole, in regards to the growing knowledge that a distressed psychologist is likely to be a professionally impaired one. In short,

> "As the importance of distress and impairment among psychologists gains greater recognition, it is hoped that research will guide the development and implementation of effective prevention and intervention programs. Financial and logistical support for these programs from the profession's policymakers and leaders will be essential." (Sherman and Thelen, 1998, p84).

1.7.4 Research on Clinical Psychology Trainees

Within the profession of clinical psychology a number of studies have focused upon the experience of stress amongst clinical psychologists during their training. Lamb, Presser, Pfost, Baum, Jackson, and Jarvis (1987) discuss how aspects of the training process leave trainees particularly vulnerable to stress. They suggest that the transition to training, changes in social and occupational circumstances, the experience of a full clinical caseload, and the close scrutiny of their professional behaviour by supervisors and the training course all combine to form a potentially stressful situation.

One of the first studies of stress levels amongst clinical psychology trainees was carried out by Cushway (1992). She found that trainees in their second or third year of training experienced significantly more stress than their first year counterparts, and that 75% of trainees sampled felt they had either been moderately or very stressed as a result of training. Scores on the General Health Questionnaire (Goldberg, 1978), indicated that 59 per cent of the sample were at or beyond cut off for caseness, with women scoring significantly higher than their male colleagues. An analysis of the factors causing stress among the trainees indicated that the six factors; course structure and organisation, workload, poor supervision, disruption of social support, self-doubt, and client difficulties / distress, accounted for 45% of the outcome variance, with the most frequently reported stressor being that of poor supervision.

Trainees were also asked to identify factors that they felt would make training a less stressful experience. They identified more support from course staff, improved organisation of course, fewer work demands, personal therapy for stress management, and more communication as potentially ameliorating factors.

More recently, Kuyken, Peters, Power, and Lavender (1998) carried out a cross sectional survey of psychologists in clinical training investigating how psychological adaptation related to cognitive style, coping, and social support variables. Trainees surveyed reported high levels of stress, and a significant sub-group reported problems in the areas of self esteem, work adjustment, depression and anxiety. Kuyken *et al.* (1998) also found that coping style was related to psychological adaptation, with avoidance coping being related to poorer adaptation. Satisfaction

with emotional support from clinical colleagues, the training course, and from non-work supports were all associated with higher levels of psychological adaptation.

In a follow up to this study Kuyken, Peters, Power, Lavender, and Rabe-Hesketh (2000) carried out a study designed to measure longitudinal psychological adaptation. The results of the study indicated that a significant proportion of trainees reported poorer psychological adaptation compared to the standardisation sample, particularly in the areas of self-esteem, work adjustment problems, anxiety and depression. The longitudinal data showed that apart from the depression and work adjustment scales, both of which increased over time, measures of psychological adaptation at an individual level remained stable over time.

In a further study on clinical psychology trainees Brooks (1999) examined the relationship between personality characteristics, course expectations, and psychological adaptation among a cross section of psychologists in clinical training. She found that 8.2% of the respondents scored within the maladjusted range on a personality adjustment scale. In terms of psychological adaptation the findings showed that 23% were experiencing significantly low self-esteem, 17.5% significant anxiety, and 13.9% significant levels of depression. The findings indicated that personality adjustment had direct links with levels of anxiety, depression, and low self esteem amongst trainees, and that a small sub-group experience significant problems during their training experience.

1.7.5 Research on Clinical Psychologists

Cushway and Tyler (1994) report on the general paucity of literature regarding stress among clinical psychologist in the UK, despite the well established finding that other mental health professionals experience considerable amounts of stress. A study by

Sampson (1991), among clinical psychologists in Scotland reported that 68% considered themselves to be moderately or very stressed as a result of their occupation, with an estimated level of caseness for this group of 33 %. Cushway and Tyler (1994) surveyed 151 clinical psychologists in the UK using the GHQ, a stress survey and a coping questionnaire. Their results showed that 75% of their sample reported being moderately or very stressed, with 29.4% scoring at a level of caseness on the GHQ. This compares with 50% caseness in a study by Cushway, Tyler and Nolan (1996). Cushway and Tyler's (1994) stress survey results were correlated with impact on self, work, relationships, and social life. Overall, stress was correlated with age and years of experience, with females scoring higher levels of stress than their male counterparts. A seniority effect was observed in males, but not in women.

In terms of the causes of stress, too much work, poor management, too many different things to do, and conflicting professional relationships were the most commonly reported sources of stress. The most frequent coping behaviours cited were talking to a colleague, exercise, and talking to partner. Psychologists were also asked about ideas regarding reducing stress at work, to which the most common answers were, better support from colleagues, better NHS management, and better supervision and training. Their findings show that although GHQ caseness was lower in a qualified sample as compared with a trainee sample, the overall reported stress levels were the same. Cushway and Tyler suggest that either clinical psychologists cope better with stress, or are less willing to admit psychopathology.

Cushway and Tyler (1996) summarise their studies on clinical psychologists in the UK with reference to the relevant (mainly US) literature. They address four main

questions of; How stressed are clinical psychologists? Which ones are stressed? What are the main sources of stress? and What coping strategies are used?

They compare their studies with those carried out in the US which often contain a mixture of professions carrying out psychotherapy, but they feel meaningful comparisons can be made.

They found that between 30% and 40% of clinical psychologists reach caseness on the GHQ, and that these scores correlate highly with a general measure of stress on which up to 75% of samples report being moderately or very stressed. Women and younger psychologists are most at risk of stress, with the presence of a partner and children acting as buffers to stress.

Their studies indicate that a reduction in family or social support can relate directly to psychological distress. In particular the quality of support given by the closest confidant is highly correlated with well-being (Cushway and Tyler, 1994). Stressors largely fell into seven categories; self doubt, home-work conflict, organisational structure, relationships and conflicts with other professionals, workload, lack of resources, and client related difficulties. Avoidance coping processes, (cognitive or behavioural) were associated with poorer well-being. Cushway and Tyler (1996) summarise;

> "Whether stress translates to mental ill-health depends on the influence of a number of mediating variables and to some extent this only confirms what the transactional model predicts. Nevertheless, these findings begin to shed new light on some of the risk factors involved." (Cushway and Tyler, 1996, p148).

1.7.6 Summary

In summary clinical psychologists can be seen as being particularly vulnerable to experiencing distress due to a range of factors including their own personality, the nature of the work that they do, and the potential lack of support systems available

for them. Studies investigating distress amongst psychologists indicate high incidences and suggest that experienced distress is associated not only with personal ill health, but with impairment of professional function.

The main rationale and aim therefore of this study is to investigate further the extent of distress amongst clinical psychologists, and of the support systems available to them, in an effort to understand better the relationship between the two, and highlight any other factors of potential importance.

1.8 Introduction Summary: An Integrated Model of Stressors, Coping, Support and Well Being

An examination of the research literature into the constructs of stress, coping, and support mechanisms highlights both their individual complexity, and the complexity of the interactions between them. Central to these complexities is the notion of a transactional relationship between the individual and their environment, with both contextual and dispositional factors characterising the nature of the transaction, and the outcome of any interaction being dependent upon the level of equality within it.

It is beyond the scope of this project to examine all of the inter-relationships between the constructs described in the previous sections, but the data gathered does allow an examination of associations between some of those that the literature would suggest are important in the prediction of well-being amongst clinical psychologists. The figure on page 79 (Figure 1.12) shows a combined model of the major relationships existing between the previously described constructs. Within the model double headed arrows indicate bi-directional associations, while single headed arrows indicate an association in the direction indicated. The brackets within the diagram

indicate how in any one situation all of the constructs are likely to be influenced both by predisposing dispositional factors, and current contextual factors.

While within the model the pathways between work and life pressures and well being are separated to a certain degree, it is accepted that there is likely to be significant associations between social and professional stressors and support systems that are not highlighted in the model.

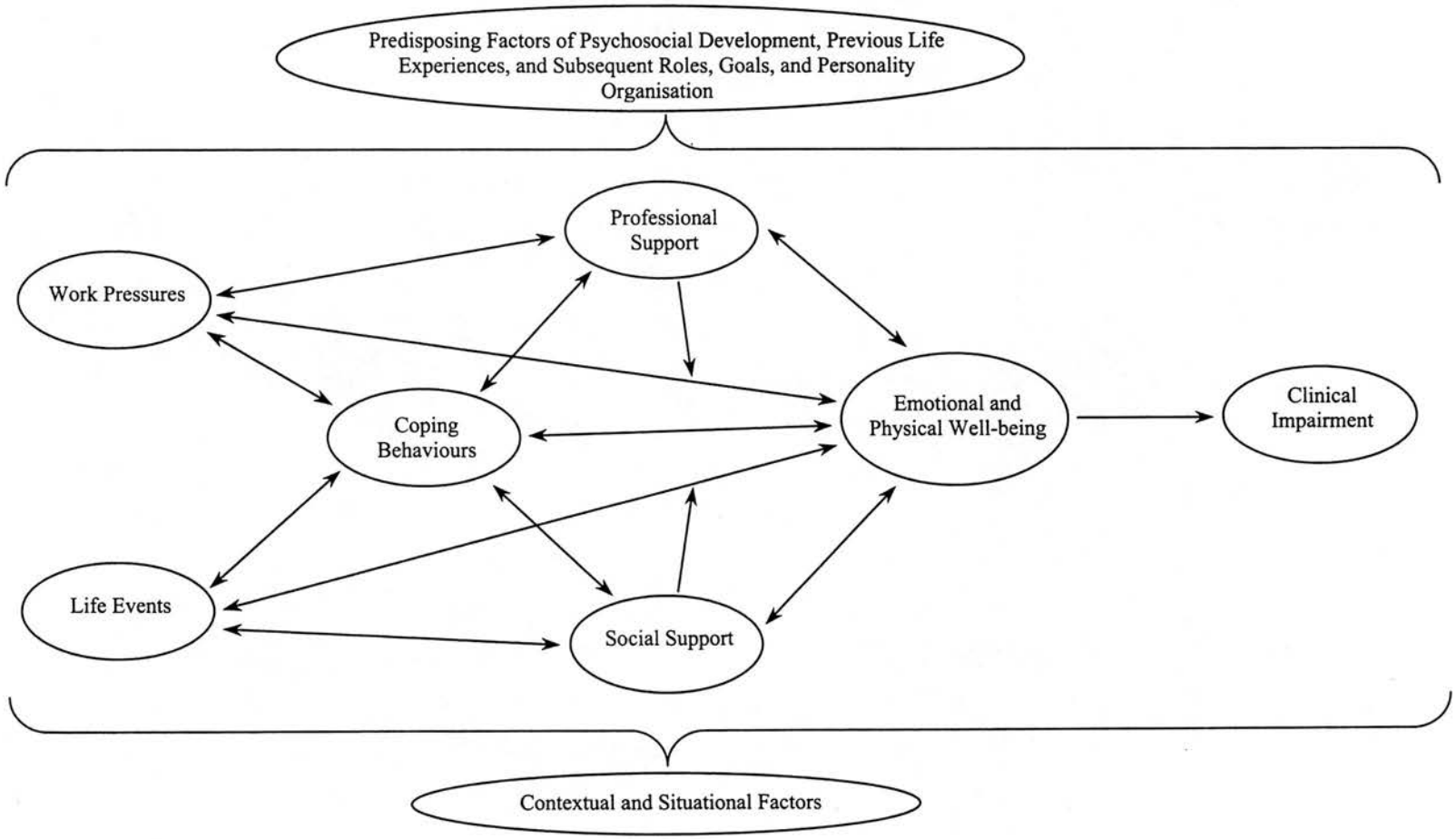


Figure 1.12 A combined model of stressors, coping, support, well being, and clinical impairment.

1.9 Aims and Hypotheses of Present Study

1.9.1 Aims

Aim 1. To investigate the professional and personal demographics of a clinical psychology population, and how these relate to the experience of stressors and well being among that population.

Aim 2. To investigate the prevalence of specific professional support systems available to clinical psychologists, and how their availability relates experienced works stressors, and to well being.

Aim 3. To investigate the relationship between reported professional impairment and reported work stressors, and well being.

Aim 4. To investigate the prevalence of, and relationship between work and non-work stressors, and well being among a population of clinical psychologists.

Aim 5. To examine the prevalence and satisfaction with general social and professional supports and how these relate to well being.

Aim 6. To investigate the relationships between the prevalence and satisfaction with general social and professional supports, and work and non-work stressors.

Aim 7. To investigate how ways of coping relate to well being.

Aim 8. To investigate to what extent reported levels of support moderate any stressor / well being relationship.

Aim 9. To measure to what extent the measured demographic, stressor, support and coping variables contribute to reported well being.

Aim 10. To investigate the factors clinical psychologists view as stressful about their work, and what they feel would ease their experience of work stressors.

Aim 11. To investigate the general level of distress amongst a population of clinical psychologists, and add to the developing literature on the subject.

Aim 12. To provide further reliability data for two of the scales used (Ways of Coping, and Mental Health Professionals Stress Scale)

1.9.2 Hypotheses

Hypothesis 1. The first hypothesis predicted that female psychologists would report higher levels of psychopathology than their male colleagues.

Hypothesis 2. The second hypothesis predicted that single psychologists would report higher levels of psychopathology than those with partners.

Hypothesis 3. The third hypothesis predicted that psychologists receiving supervision would report higher levels of work stressors and lower levels of psychopathology than their non-supervised colleagues.

Hypothesis 4. The fourth hypothesis predicted that reports of work impairment would be positively correlated with reported psychopathology and with experience of work stressors.

Hypothesis 5. The fifth hypothesis predicted that the values of various descriptive variables would be associated with reported psychopathology and experience of work stressors. Specifically the variables of; hours worked per week, and hours of supervision provided would be positively correlated with psychopathology and work stressor scores, while the values of the variables of; age, years since qualification, hours of continued professional development per month, hours of personal therapy per month, and hours of received supervision would be negatively correlated with psychopathology and work stressor scores.

Hypothesis 6. The sixth hypothesis predicted that there would be a positive correlation between reported experiences of work stressors and reported psychopathology.

Hypothesis 7. The seventh hypothesis predicted that there would be a positive correlation between reported experience of life stressors and reported psychopathology.

Hypothesis 8. The eighth hypothesis predicted that measures of both social and professional support would be associated with reported psychopathology. Specifically it was predicted that measures of perceived emotional support, practical support, and reported support network size would be negatively correlated with psychopathology, while measures of discrepancy in emotional and practical support would be positively correlated with psychopathology

Hypothesis 9. The ninth hypothesis predicted that measures of support would be associated with measures of stressors. Specifically it was hypothesised that measures of perceived emotional and practical support, and total network size would be negatively correlated with scores on stressor scales, while discrepancy scores for emotional and practical support would be positively correlated with stressor scores. Furthermore it was predicted that social support and professional support would exert greater effects upon life stressors and work stressors respectively.

Hypothesis 10.The tenth hypothesis predicted that the use of emotion focused ways of coping would be associated with higher reported psychopathology, while the use of problem focused ways of coping would be associated with lower reported psychopathology.

Hypothesis 11.The eleventh hypothesis predicted that measures of support would moderate the relationships between stressors and reported well being. Specifically it was predicted that social support measures would moderate any life event / well being relationship, while measures of professional support would moderate any works stressor / well being relationship.

2. Method

2.1 Background and Preparation

This study grew out of the clinical experiences of the author during his training in clinical psychology. Within those experiences he was often supervised by clinical psychologists who were not receiving supervision themselves and often had no reduction in case load to allow for having a trainee under their supervision. On one occasion, a supervisor reported feeling very stressed by the experience of supervising a trainee without receiving supervision themselves, and without having had prior training or experience in supervision.

Prior to undertaking the study a proposal was approved by members of the training course staff (appendix 1). Ethical approval was sought from the University of Edinburgh's Psychology Department Ethics Committee (appendix 2) and was passed in its submitted form.

Literature searches were carried out using MEDLINE and PsycINFO in order to identify any previous studies carried out in the area.

A power analysis was performed using PC-Size (Dallal, 1986) in relation to the design of the study. The limits of the power analysis were set to detect weak to low correlations ($r = 0.3$), and between group differences of 0.3 standard deviations of the mean. The alpha levels were set at 0.05, and the required power at 0.8. Using these values sample sizes were required of 84 for correlations, 52 per cell for paired t-tests, and 176 for between subjects t-tests were required.

With an initial sample size of 357 and an estimated return rate of 50% (N=178) it was determined that the study design was powerful enough to answer the research questions.

2.2 Design

A correlational design was used to examine the relationships between the demographics, stressors, support, coping styles and well being of clinical psychologists. A qualitative component was used to gain information about work stress and ideas about the relief of that stress. A between subjects design was used to compare values on a range of variables. Between group variables included sex, relationship status, and supervision status. The study was a population study and recruited participants nationally within an eight week time frame. Data was collected using a postal survey that contained a range of quantitative and qualitative measures. The main dependent variable measured was psychological and physical well being, and the experience of work stressors was also used as a dependent variable in some of the analyses. Independent variables measured included a range of personal and professional demographics, stressors related to work and to life outside of work, social and professional support, and ways of coping.

2.3 Subjects

The subjects for the study were clinical psychologists working in Scotland. Their names were taken from the University of Edinburgh's Department of Clinical Psychology mailing list and the 2000/2001 British Psychological Society's register of chartered psychologists. There was no exclusion criteria in the selection of clinical psychologists. Cross referencing for duplications between these two sources led to an initial subject pool of 357.

2.4 Materials

The materials used comprised a range of measures chosen in line with the constructs under examination in the study.

2.4.1 Stress Survey Demographic Cover Sheet

The demographic cover sheet (appendix 3) was designed specifically for the present study to gain information on participants demographics, work specialism, theoretical orientation, and also quantity of supervision, continued professional development, and personal therapy.

The cover sheet also contained two likert scales measuring how stressed participants felt by their work, and how much they felt this stress impaired their work. In two further questions, participants were provided with an open ended opportunity to write down the things that they thought caused them the most stress at work, and what they thought would make their work less stressful.

The two likert scales were included to provide confirmation of the dependent variable outcome measure, and to provide a rough measure of impairment respectively. The open ended questions were included to provide supporting information for the quantitative measures of stressors.

2.4.2 Mental Health Professionals Source of Pressure Scale

The Mental Health Professionals Source of Pressure Scale (MHPSS) (Cushway, Tyler, and Nolan, 1996) was used to measure the psychologist's experience of stressors. The MHPSS is a self report scale developed to identify sources of stress (stressors) for mental health professionals (appendix 4). The scale comprises 42 items, that make up seven subscales of sources of pressure. Each of the items is answered on a four point scale ranging from 0 (Does not apply to me) to 3 (Applies

to me always), with higher scores representing higher levels of work pressures. The seven subscales produced from item scores relate to areas of potential pressure and are termed; Workload, Client-related difficulties, Organisational structure and processes, Relationships and conflicts with other professionals, Lack of resources, Professional self-doubt, and Home-work conflict.

Cushway, Tyler and Nolan (1996) provide data from 154 clinical psychologists and 111 mental health nurses indicating that the scale has good internal validity with Cronbach's alpha's ranging from 0.60 to 0.87 for the subscales, and good criterion validity with high correlations between the MHPSS and other measures reporting to measure stress. In summary, Cushway *et al.* (1996) conclude that both the total scale and subscales of the MHPSS are internally consistent, and that the scale has a higher face validity for mental health professionals than any existing scale, since the items are relevant and the terminology used is population and context specific. Further support for the scale has come from Mehrotra, Rao and Subbakrishna (2000) who carried out a validation study amongst 116 Indian clinical psychologists, and concluded that the MHPSS is an internally valid (Cronbach's alpha scores ranging from 0.64 to 0.89) and externally valid tool to measure stressors experienced by mental health professionals.

The most widely used measure of stress among health professionals is the Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1981). The MHPSS was chosen in favour of the MBI because it has been argued that as burnout is a response to chronic stressors, the MBI is more akin to an outcome measure as opposed to a measure of experience of stressors. Thus the use of the MHPSS allowed stressors to be measured separately from outcome in the study.

2.4.3 Life Events Scale

A modified version of The Life Experiences Survey (Sarason, Johnson, and Seigel, 1978) was used to measure psychologists' experience of stressors outside of work (appendix 5). The scale used comprised 20 of the original 47 items on the Life Experiences Survey, and five blank items in which respondents could enter a life experience relevant to them. Each of the items is answered on a four point scale ranging from 0 (Does not apply to me) to 3 (Applies to me always), with higher scores indicating higher levels of pressures outside of work. In line with the original survey, the scale was used to yield an overall score for life events.

2.4.4 Significant Others Scale – Social

Social support was measured in the study with the use of the short version (Power, 1988) of the Significant Others Scale (Power, Champion and Aris, 1988). Two scales were used in this study, one of which provided the participant with seven significant others to rate (appendix 6) and one which allowed the participant to choose up to seven significant others to rate (appendix 7). The scale is designed to measure four different functions of social support (two emotional, and two practical) in each of the individuals being rated. For each function of social support the individual being rated is given a score for actual and ideal levels of support. The scale therefore gives average measures of actual support, ideal support, and the discrepancy in support (ideal – actual) for each support type.

Power *et al.* (1988) in a study of 135 female mature students, found that the scale showed satisfactory test-retest reliability, and criterion validity. In addition to this, the scale was chosen for the study because, in line with the research on social support, it distinguishes between the structural and functional aspects of social

support, whilst retaining the emotional / practical division within the functional dimension of support. Furthermore the scale allows a measure of over- and under-provision of support, provides information about the quality of support, and measures perceived support, in preference to received support (Power *et al.*, 1988). Within the study the scale was used to produce scores relating to average actual emotional and practical support (perceived support), and average discrepancy between ideal and actual, emotional and practical support (support satisfaction). Thus four measures of support were obtained from the scale.

2.4.5 Significant Others Scale – Professional

Professional support was measured with a modified version of the Significant Others Scale (Power *et al.* 1988). As with social support, two scales were used, one which provided the participant with potential professional supports to rate (appendix 8), and one which allowed the participant to chose up to seven other professional supports to rate (appendix 9). The professional supports listed in the first scale were generated from discussions with clinical psychologists, and the author's experience in clinical psychology departments and multi-disciplinary teams. The list used was; Clinical supervisor, Personal therapist, Boss / Head of department, Non-supervising colleague, Group supervision, Other colleague, and Professional development / Education group.

In addition to these changes the second practical support question's (question 4 on the scale) wording was changed from, "Can you spend time with them socially?", to, "Does this person / group help you develop new work skills?". The wording change was designed to represent a practical supportive function that was appropriate from a

professional support. Apart from these modifications the scale was identical to that described in the previous section, and yielded the same type of scores.

2.4.6 Ways of Coping Scale

Coping behaviours were measured using the short version of the Ways of Coping Questionnaire (WCQ) (Folkman and Lazarus, 1988). The version of the WCQ used in the study (appendix 10) is a self report scale comprising 31 items, each of which is answered on a four point scale ranging from 0 (Didn't Use) to 3 (Used a Great Deal). In line with the arguments presented in the introduction, participants were asked to answer the questionnaire in response to one stressful situation that they had recently experienced, but it was assumed that their responses were at least partially representative of a more general style of coping.

The scoring of the questionnaire was determined in line with the arguments presented in the introduction with items classified as emotion focused or problem focused with higher scores on each group indicating more frequent use of that coping strategy.

The WCQ was chosen both because it is the most widely cited coping questionnaire in the research literature (DeRidder, 1997) and because it has been used in previous studies examining stress and coping in health professionals (Murtagh and Wollersheim, 1997).

2.4.7 General Health Questionnaire

A scaled version of the General Health Questionnaire (GHQ) (Goldberg, 1972) termed the General Health Questionnaire – 28 (GHQ-28) (Goldberg and Hillier, 1979) was used in the study as the primary outcome measure. The GHQ-28 was not designed as a stress measure but has been widely used as a measure of general

distress in a wide range of studies examining occupational stress (Cushway and Tyler, 1996), and is commonly used as a screening device for minor psychiatric illness in a general population (Cleary, Goldberg, Kessler, and Nycz, 1982).

The GHQ-28 was developed from a principal axes analysis of responses to the original 60 item GHQ yielding four factors that accounted for 59% of the total variance. These four factors are somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. The seven items with the highest loadings on each of the four factors were chosen to give a final scale of 28 items yielding scores for each of the four factors, and an overall score (Goldberg and Hillier, 1979).

The GHQ-28 as used in this study (appendix 11) therefore comprises 28 items to which participants respond by circling one of four options ranging from a statement indicating that they have not been experiencing the symptom at all, to a statement indicating that they have been experiencing it much more than is usual for them. The GHQ-28 has two methods of scoring termed the likert method (0-1-2-3), and the GHQ method (0-0-1-1), with higher scores indicating poorer health. Within this study, means for the scale and its subscales were measured using the likert method, and estimation of caseness, described in the GHQ manual as, 'just significant clinical disturbance', was assessed using the GHQ method. In line with the current research on the GHQ-28 (Goldberg, Oldehinkel, and Ormel, 1998; Lykouras, Adrachta, Kalfakis, *et al.* 1996) and with other studies examining stress amongst clinical psychologists (Cushway and Tyler, 1996; Darongkmas, Burton and Cushway, 1994; Sampson, 1991) a cut off level for caseness was set at 4/5 with scores of 5 or above on the GHQ method of scoring indicating caseness.

The GHQ-28 was chosen for the study for a number of reasons; Its relative ease of use (Cushway and Tyler, 1996), the fact that it has good reliability and validity (Goldberg and Hillier, 1979; Goldberg, Gater, Sartorius, *et al.* 1997), its production of mean, subscale and caseness scores, and the ability to allow direct comparison with other studies in the area which have utilised it (Cushway and Tyler, 1996; Sampson, 1991).

2.5 Procedure

The study was conducted by a postal survey. In the first instance all the identified subjects (N=357) were sent a pack containing a letter explaining the background to the study, an assurance of anonymity, a request for participation, and a brief description of the questionnaires (appendix 12). The pack also contained a copy of all the materials described above, and a stamped addressed envelope for the return of the completed questionnaires. Five weeks after this initial mailing, a second mailing was carried out to all the original recipients (apart from those who had been identified as inappropriate as a result of the first mailing, N=12) reminding them of the closing date of the study and thanking them should they already have taken part (appendix 13). The closing date for data collection was three weeks after this second mailing.

2.6 Data Management and Analysis

Questionnaires were deemed unusable if any of the questionnaires were not filled in, and were omitted from any analysis. A breakdown of this is contained in the results. All data from the returned surveys were entered raw into a database on the statistical package SPSS for Windows, release 10.1.0 (SPSS Inc., 1989-2000). All subsequent

calculations of questionnaire and subscale totals, and other statistical operations were carried out using SPSS.

Qualitative data was analysed using an Editing Analysis Style (EAS) approach (Figure 2.1) where response categories were developed using a combination of subjective, intuitive, and particular processes (Miller and Crabtree, 1992) after all the questionnaires had been returned.

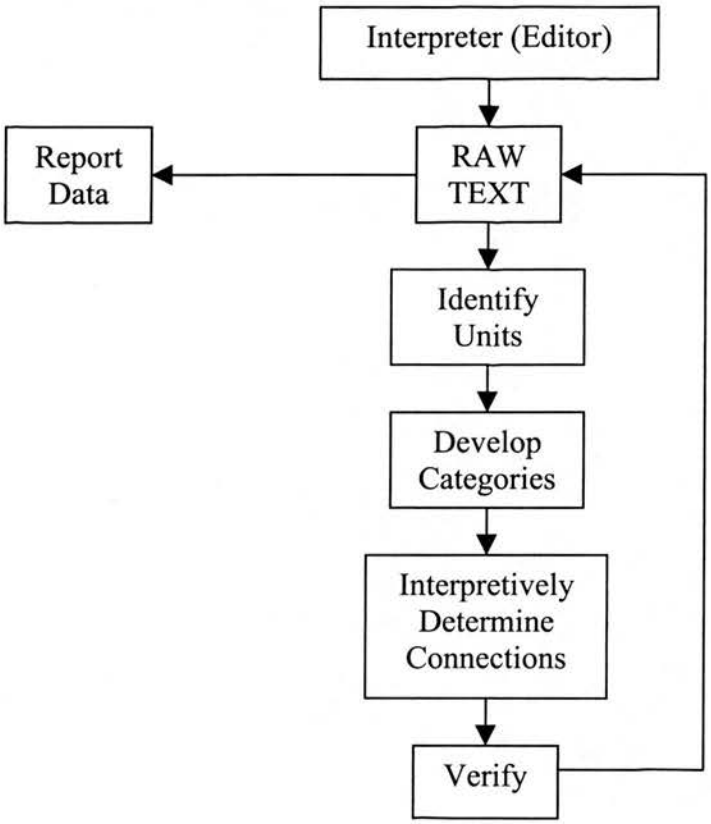


Figure 2.1 Editing analysis style of data analysis

Categories were created either as a direct reflection of a given answer (e.g. "Clinical workload", "Lack of supervision"), or in an intuitive manner as a response to a broader range of responses, (e.g. "Home / work conflict", "Concerns about colleagues"). Validation of the categorisation process was attempted through giving a

random sample of questionnaires (every tenth questionnaire, N = 18, 76 responses) to a different categoriser, who then re-categorised the responses into the developed categories. This was then compared with the original categorisation done by the researcher. There was complete agreement between the main researcher and the re-categorisers categorisation of the 76 responses.

Across the total sample 49 categories were generated from a total of 676 responses for the two questions.

3. Results

All data were entered into the database in raw form. Where appropriate, data were then transformed into variables representing the various scales and subscales of the measures used in the study.

Prior to data analysis all variables were examined for departures from normality, in line with the recommendations for the use of parametric statistics (Greene and D'Oliveira, 1982). However it was borne in mind that it has been repeatedly demonstrated that t-tests, ANOVA, and regression analysis are generally robust procedures in the presence of departures from parametric assumptions (Pedhazur, 1982). Ferguson (1982) suggests that the major difficulty in using parametric statistics with data that strays from the parametric assumptions is that it brings about a rise in type-I errors, a difficulty which can be overcome by the use of more conservative alpha levels.

Within this study data was presumed to be within acceptable limits for the use of parametric statistics if measures of skewness and kurtosis fell with the range of –1.00 and + 1.00. Unless otherwise stated in the results the data should be assumed to have values falling within these parameters.

A complete correlation matrix of all measured variables is contained in the appendix (appendix 14).

3.1 Response Rate

Of the original 357 surveys sent out, 201 (56.3%) elicited a response. Of this 201, four (1.1%) were returned unusable, all due to non-completed questionnaires, two (0.6%) were returned unknown at the address, and fifteen (4.2%) responded stating that for a variety of reasons they were unable, or unwilling to complete the survey.

This left a usable response rate, and experimental sample of 180 (50.4%) surveys all of which were included in the data analysis. Table 3.1 provides a summary of the response figures.

The total response rate of 56.3% was lower than the 67% reported for a local English population by Cushway and Tyler (1996), but comparable with the response rates of similar American population studies where response rates range between 40% and 54% (e.g. Good, Thoreson, and Shaughnessy, 1995; Coster and Schwebel, 1997).

Table 3.1 Summary of response figures

Category	Number	Percentage of total surveys sent
Forms unusable due to missing data	4	1.1%
Returned unknown at the address	2	0.6%
Retired	7	2.0%
On maternity leave	3	0.8%
Did not want to participate	1	0.3%
Felt they were inappropriate subjects	4	1.1%
Usable surveys	180	50.4%
No response	156	43.7%
Totals	357	100%

3.2 Descriptive Variables of Sample

3.2.1 Age

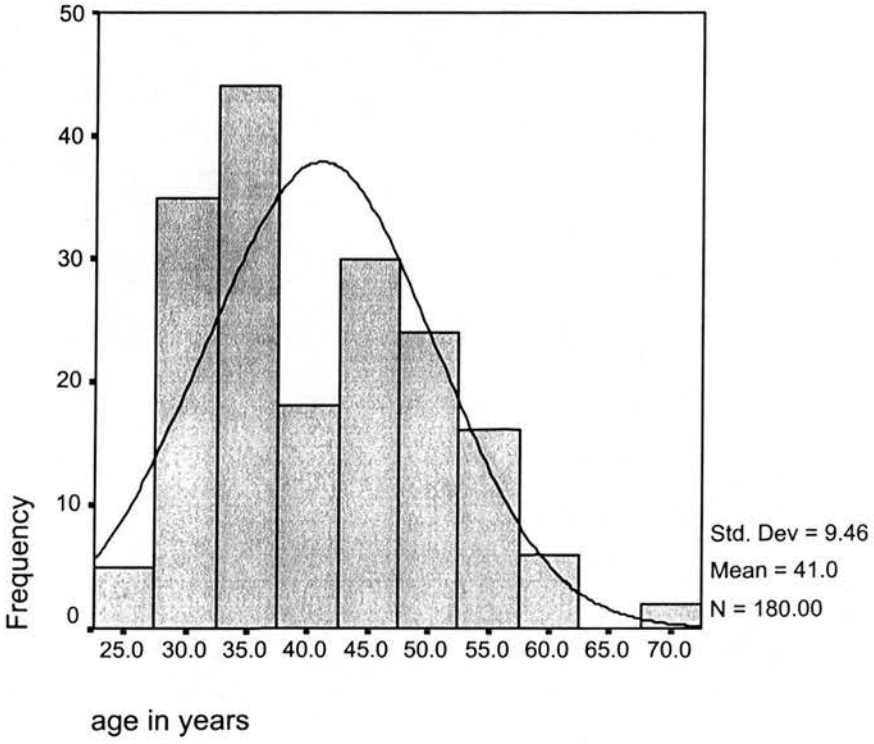
The mean age of the sample was 41.0 years (s.d. = 9.46 years), with a minimum age of 26 years, and a maximum of 70 years. Table 3.2 summarises the age distribution of the sample.

Table 3.2 Distribution of age of total sample

	Statistic	Value
Age in Years	Mean	41.0
	Standard error of mean	0.71
	Standard deviation	9.46
	Range	44.00
	Minimum	26.00
	Maximum	70.00

Chart 3.1 shows the distribution of age across the sample group.

Chart 3.1 Age distribution of total sample



An independent samples t-test for equality of mean age between sexes showed that there was a significant age difference between the two groups, with the male sample having a higher mean age ($t = 2.958$, $df = 178$, $p = 0.004$). Table 3.3 summarises the age distribution of the two sexes.

Table 3.3 Distribution of ages of males and females in sample

	Sex	N	Mean	Standard deviation	Standard error of the mean
Age in years	Male	43	44.7	9.63	1.46
	Female	137	39.9	9.15	0.78

3.2.2 Sex

Table 3.4 summarises the sex distribution of the participants. Of the 180 participants 43 (23.9%) were male, and 137 (76.1%) were female.

Table 3.4 Sex distribution of total sample

	Frequency	Percent of total sample
Male	43	23.9%
Female	137	76.1%
Totals	180	100.0%

3.2.3 Relationship Status

Table 3.5 summarises the relationship status of the sample. Of the 180 participants, 41 (22.8%) were single, and 139 (77.2%) were with a partner.

Table 3.5 Distribution of relationship status of total sample

	Frequency	Percent of total sample
Single	41	22.8%
With partner	139	77.2%
Total	180	100.0%

3.2.4 Years of Practice Since Qualification

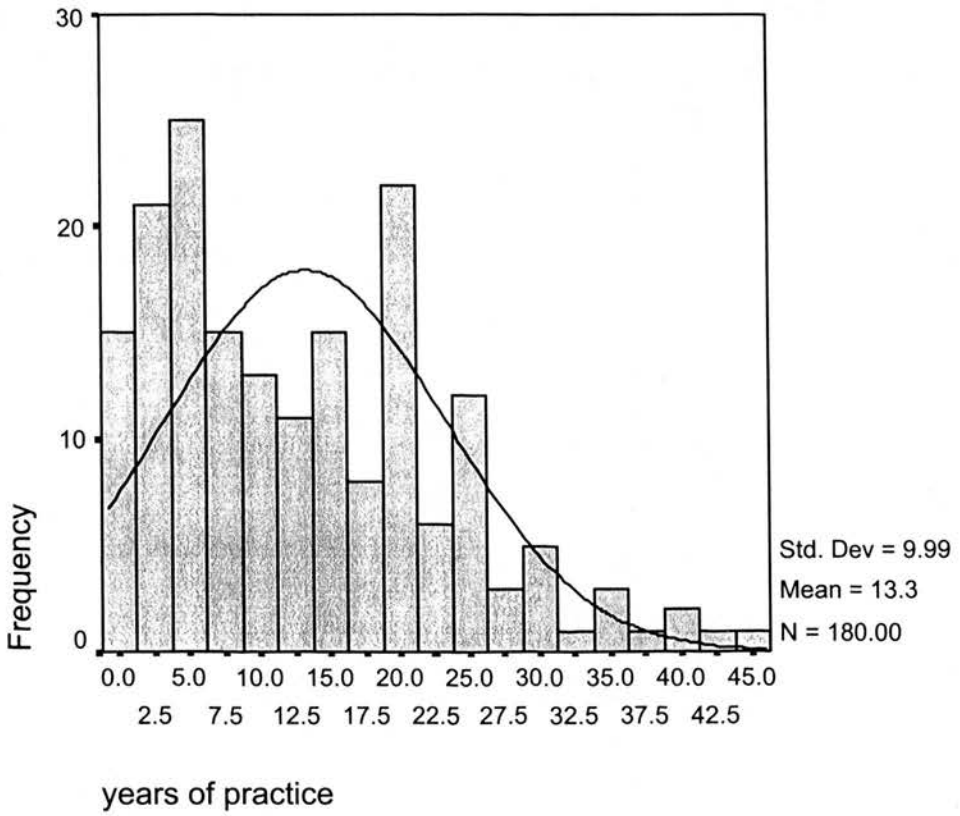
The mean years since qualification of the sample was 13.28 years (s.d. = 9.99 years), with a minimum of 0.5 years and a maximum of 45 years. Table 3.6 summarises the distribution of years since qualification across the sample group.

Table 3.6 Distribution of years since qualification of total sample

	Statistic	Value
Years since qualification	Mean	13.28
	Standard error of mean	0.74
	Standard deviation	9.99
	Minimum	0.50
	Maximum	45.00

Chart 3.2 shows the distribution of years since qualification across the sample group.

Chart 3.2 Distribution of years since qualification of total sample



An independent samples t-test for equality of mean years since qualification between sexes showed a significant difference with the male sample having a higher mean years since qualification ($t = 2.833$, $df = 178$, $p = 0.005$). Table 3.7 summarises the years since qualification distribution of the two sexes.

Table 3.7 Distribution of years since qualification of males and females in sample

	Sex	N	Mean	Standard deviation	Standard error of the mean
Years of practice	Male	43	16.9	10.50	1.60
	Female	137	12.1	9.58	0.82

3.2.5 Hours of Work per Week

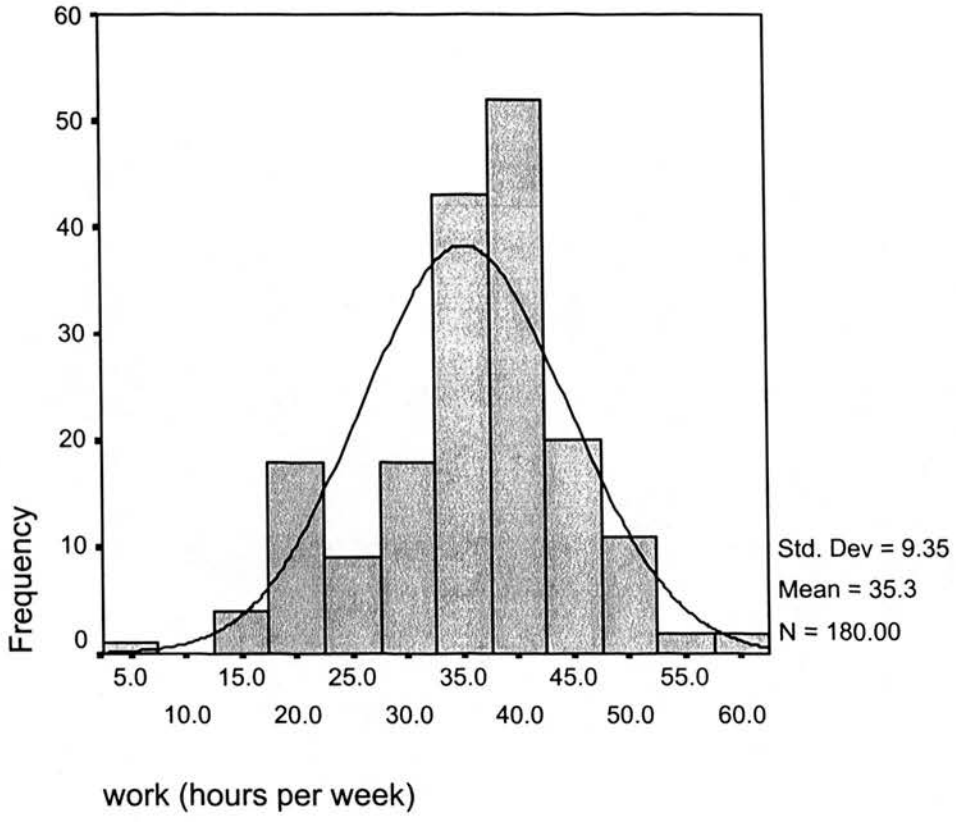
The mean hours of work per week of the sample was 35.3 hours (s.d. = 9.35 hours), with a minimum of 3 hours per week and a maximum reported working week of 60 hours. Table 3.8 summarises the distribution of hours worked per week across the sample.

Table 3.8 Distribution of hours worked per week across total sample

	Statistic	Value
Time in hours	Mean	35.3
	Standard error of mean	0.69
	Standard deviation	9.35
	Range	57.00
	Minimum	3.00
	Maximum	60.00

Chart 3.3 shows the distribution of hours worked per week across the sample group.

Chart 3.3 Distribution of hours worked per week across total sample



An independent samples t-test for equality of mean hours worked per week between sexes indicated that there was a significant difference between the sexes with males working more hours per week on average than females ($t = 3.978$, $df = 178$, $p < 0.001$). Table 3.9 summarises the distribution of hours worked per week for males and females in the sample.

Table 3.9 Distribution of hours worked per week for males and females in the sample.

	Sex	N	Mean	Standard deviation	Standard error of the mean
Time in hours	Male	43	40.08	7.51	1.15
	Female	137	33.84	9.39	0.80

3.2.6 Major Work Specialism

Table 3.10 summarises the major areas of work specialism of the sample group. The table also contains data of staffing of specialism presented in a recent review of psychological services in Scottish healthcare (SCPDME, 1999) for comparison. Within the sample adult mental health was the most frequently reported speciality (48.9%) with child and family (19.4%), and learning disabilities (10.6%) being the next two most frequently given.

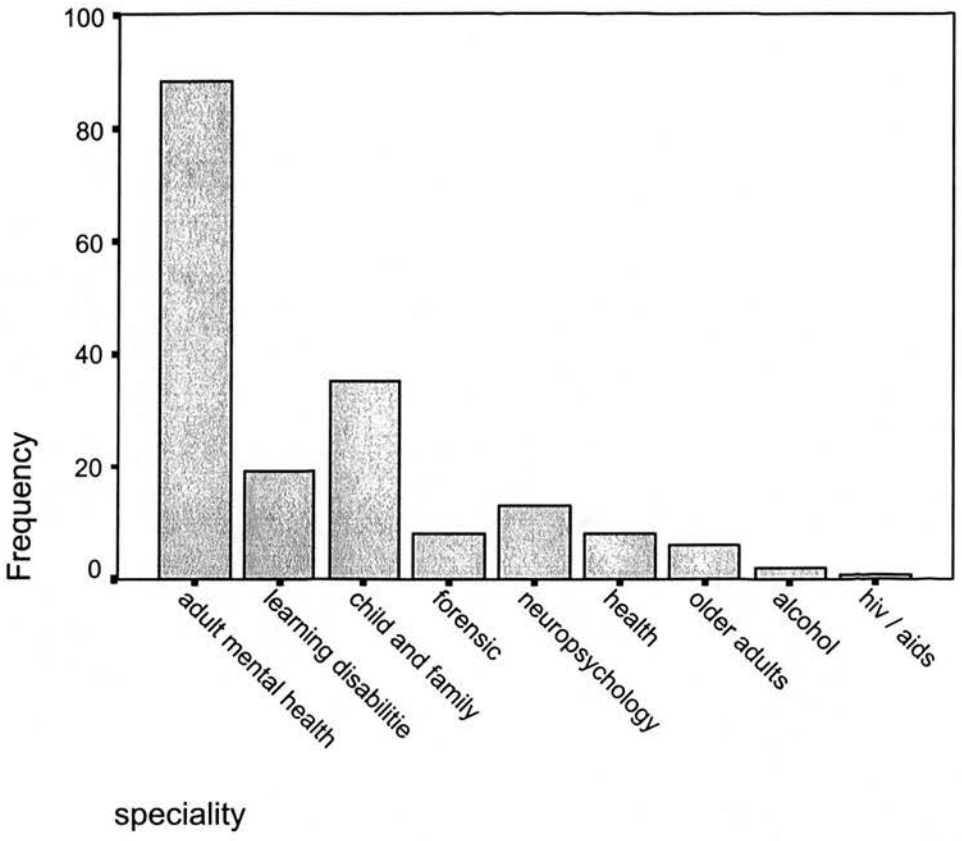
An examination of the comparative data suggests that clinical psychologists working in the field of learning disability were under-represented in the sample.

Table 3.10 Major work specialisms of total sample with comparative data

Work specialty	Frequency	Percent of total sample	Percentage reported by SCPDME (1999)
Adult mental health	88	48.9%	43.55%
Learning disabilities	19	10.6%	20.67%
Child and family	35	19.4%	14.84%
Forensic	8	4.4%	5.32%
Neuropsychology	13	7.2%	3.98%
Health	8	4.4%	3.03%
Older adults	6	3.3%	3.08%
Alcohol	2	1.1%	1.28%
HIV / Aids	1	0.6%	0.81%
Other	0	0%	3.44%
Total	180	100.0%	100.0%

Chart 3.4 presents a graphical representation of the current study data.

Chart 3.4 Major work specialisms of total sample



3.2.7 Major Theoretical Orientation

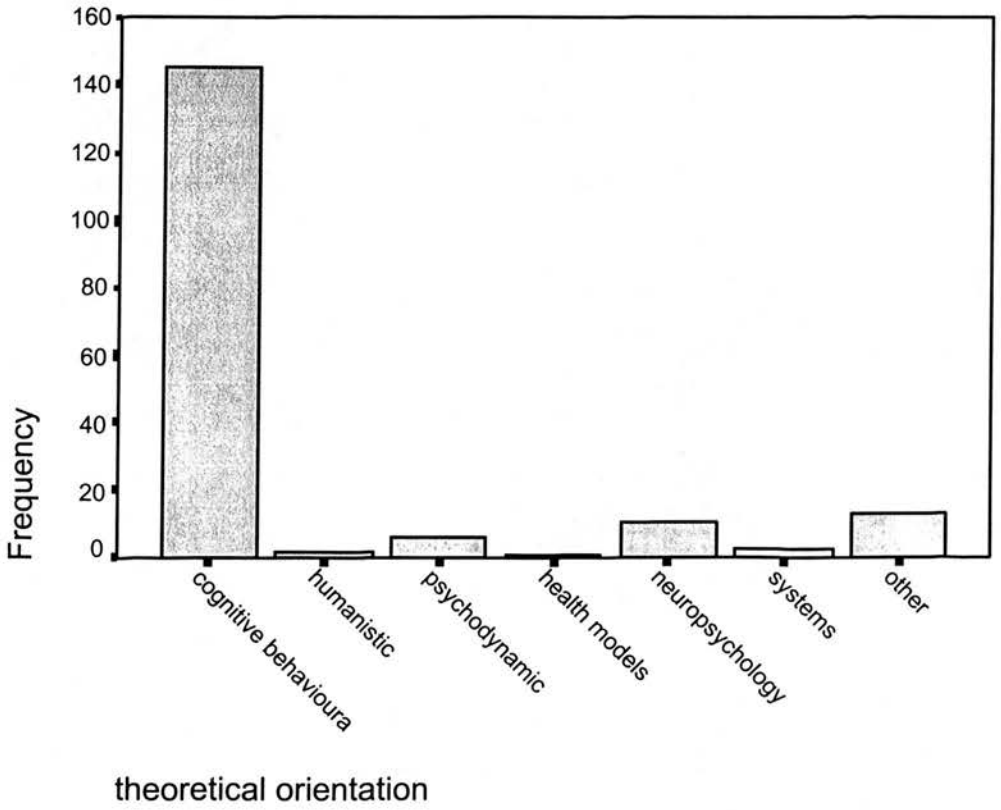
An analysis of the data regarding reported major theoretical orientation showed that a cognitive behavioural orientation was the most frequently cited (80.6%) among the sample, with neuropsychology (5.6%) and psychodynamic (3.3%) the next two most frequently reported orientations. Table 3.11 summarises the data relating to reported major theoretical orientation.

Table 3.11 Major theoretical orientations of total sample

	Frequency	Percent of total sample
Cognitive behavioural	145	80.6%
Humanistic	2	1.1%
Psychodynamic	6	3.3%
Health models	1	0.6%
Neuropsychology	10	5.6%
Systems	3	1.7%
Other	13	7.2%
Total	180	100.0

Chart 3.5 shows the major theoretical orientations of the sample group in graphical form.

Chart 3.5 Major theoretical orientations of total sample



3.3 Brief Measures of Professional Support, Stress, and Impairment

3.3.1 Clinical Supervision

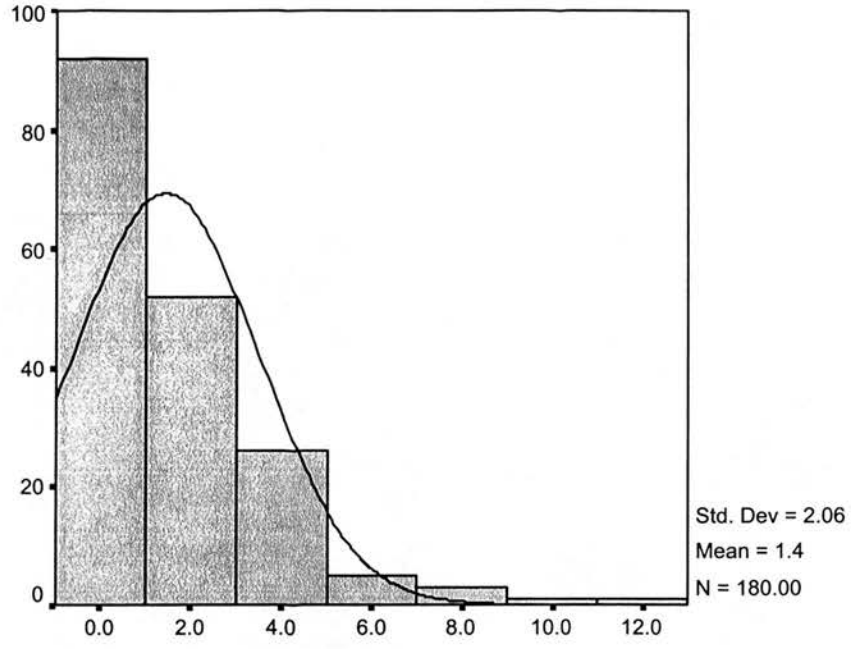
The mean number of hours supervision per month for the sample was 1.44 hours (s.d. = 2.06 hours), with a minimum of 0.00 hours and a maximum of 12.00 hours per month. The results showed that 91 (50.6%) of the sample reported receiving no supervision, while 147 (81.8%) received less than four hours of supervision per month. Table 3.12 summarises the received supervision of the sample.

Table 3.12 Summary of received supervision of total sample

Hours per month	Frequency	Percent of total sample
0.00	91	50.6%
0.50	1	0.6%
1.00	18	10.0%
1.50	4	2.2%
2.00	30	16.7%
3.00	3	1.7%
4.00	23	12.8%
5.00	2	1.1%
6.00	3	1.7%
8.00	3	1.7%
10.00	1	0.6%
12.00	1	0.6%
Total	180	100.0%

Chart 3.6 shows the received supervision data for the sample in graphical form.

Chart 3.6 Received supervision of total sample



This data had a skewness value of 2.03, and a kurtosis value of 5.35 and was therefore transformed prior to use in analysis. The data was transformed using the equation log (x+1), which produced new skewness and kurtosis values of 0.65 and -0.86 respectively.

The mean number of hours of supervision provided by the sample was 5.73 hours per month (s.d. = 6.01 hours) with a minimum of 0.00 and a maximum of 40.0 hours.

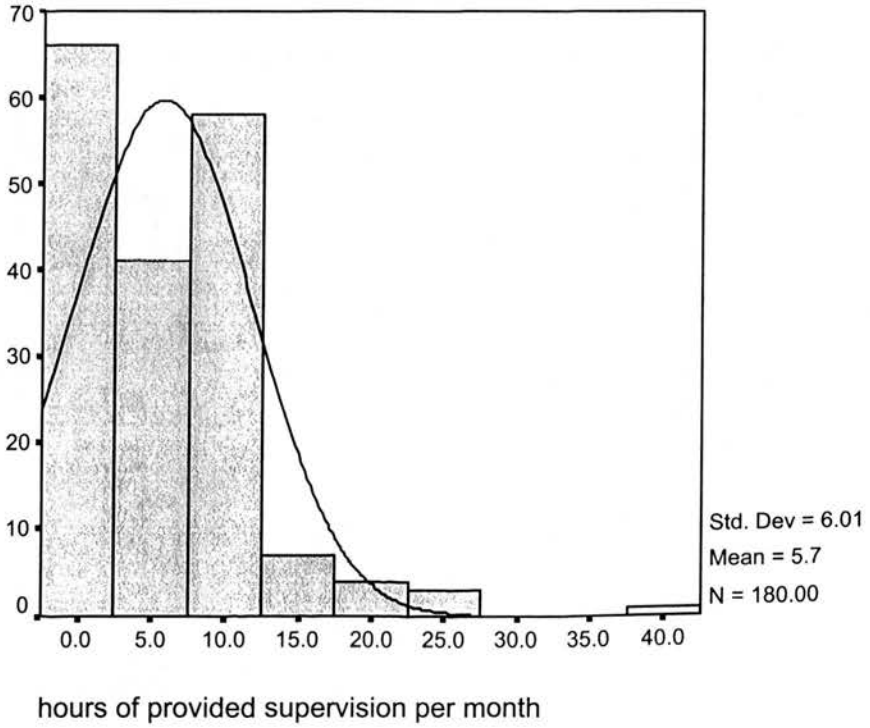
Table 3.13 summarises the number of hours of supervision provided by the sample.

Table 3.13 Summary of provided supervision of total sample

Hours per month	Frequency	Percent of total sample
0.00	47	26.1%
0.50	2	1.1%
1.00	5	2.8%
1.50	1	0.6%
2.00	11	6.1%
4.00	34	18.9%
6.00	7	3.9%
7.50	1	0.6%
8.00	41	22.8%
10.00	2	1.1%
12.00	14	7.8%
13.00	1	0.6%
16.00	6	3.3%
20.00	4	2.2%
24.00	3	1.7%
40.00	1	0.6%
Total	180	100.0%

Chart 3.7 shows the provided supervision data of the sample in graphical form.

Chart 3.7 Provided supervision of total sample



This data had a skewness value of 1.84 and a kurtosis value of 5.95 and was therefore transformed prior to use in analysis. The data was transformed using the equation log (x+3), which produced skewness and kurtosis values of 0.09 and –0.94 respectively.

A paired samples t-test for equality of means between received and given supervision showed that the sample provided more supervision than they received ($t = 18.27$, $df = 179$, $p < 0.001$). Table 3.14 summarises the distribution of received and provided supervision of the sample.

Table 3.14 Distribution of received and provided supervision of total sample

		Mean	N	Standard deviation	Standard error of the mean
Hours per month	Received supervision	1.44	180	2.06	0.15
	Provided supervision	5.73	180	6.01	0.45

3.3.2 Continuing Professional Development

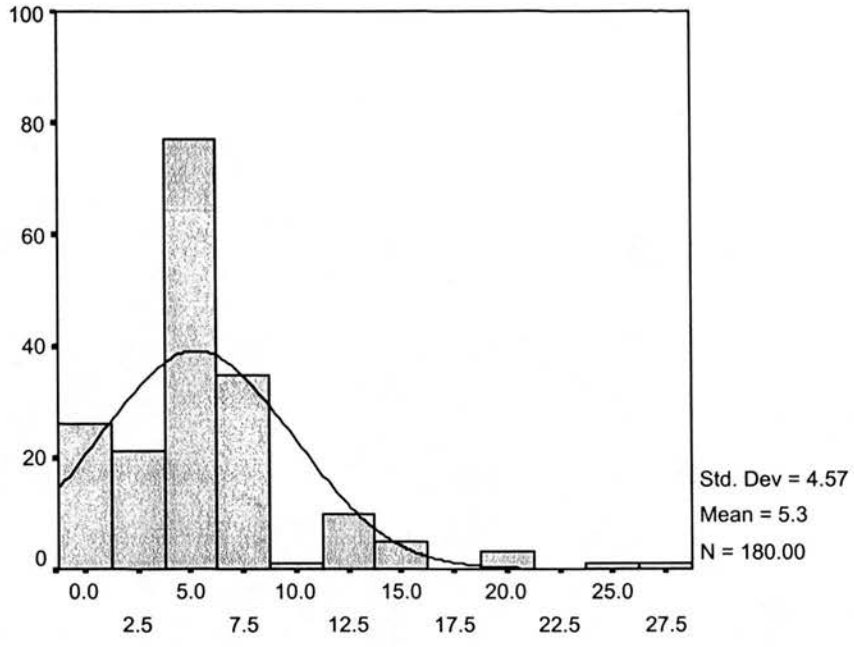
The mean hours of continuing professional development per month reported by the sample was 5.29 hours (s.d. = 4.57 hours), with a minimum of 0.00 and a maximum of 28.00 hours per month. The data shows that 22 (12.2%) of the sample received no continuing professional development. The two most frequent values reported were four hours per month by 75 (41.7%) of the sample and eight hours per month by 34 (18.9%) of the sample. Table 3.15 summarises the received continued professional development in hours per month of the sample.

Table 3.15 Received continuing professional development of total sample

Hours per month	Frequency	Percent of total sample
0.00	22	12.2%
0.50	1	0.6%
1.00	3	1.7%
1.50	1	0.6%
2.00	18	10.0%
3.00	2	1.1%
4.00	75	41.7%
5.00	1	0.6%
6.00	1	0.6%
7.00	1	0.6%
8.00	34	18.9%
10.00	1	0.6%
12.00	10	5.6%
14.00	3	1.7%
16.00	2	1.1%
20.00	3	1.7%
24.00	1	0.6%
28.00	1	0.6%
Total	180	100.0%

Chart 3.8 shows the received continuing professional development reported by the sample.

Chart 3.8 Received continuing professional development of total sample



3.3.4 Personal Therapy

The mean amount of received personal therapy by the sample was 0.28 hours per month (s.d. = 1.37 hours), with a minimum of 0.00 hours and a maximum of 12 hours per month.

The data showed that 169 (93.9%) of the sample received no personal therapy, while the most commonly reported amount of personal therapy received was four hours per month by four (2.2%) of the sample.

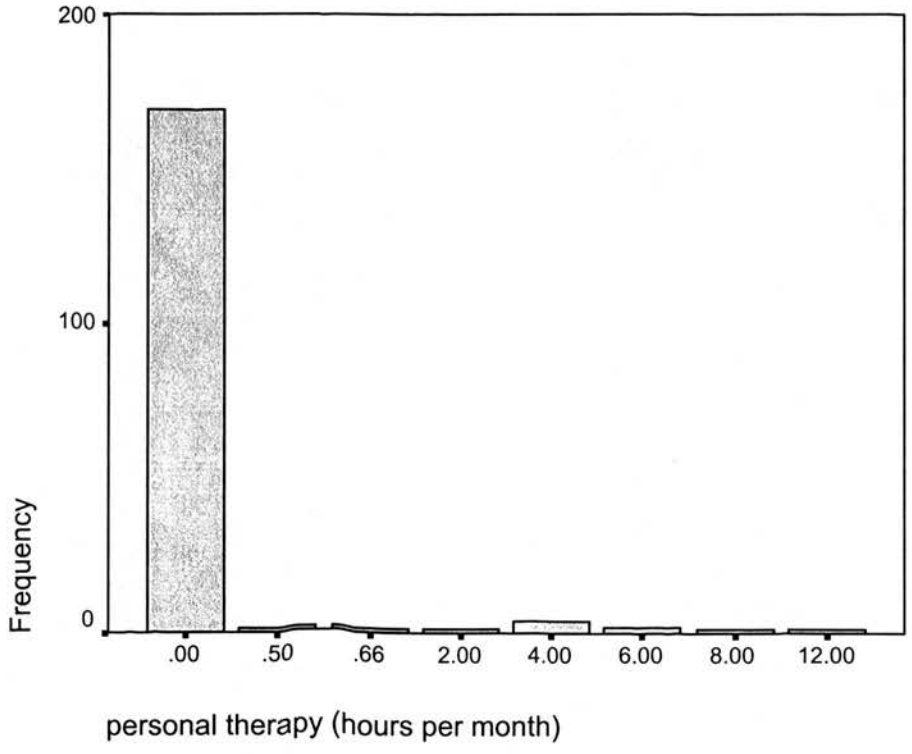
Table 3.16 summarises the received personal therapy of the sample.

Table 3.16 Received personal therapy of total sample

Hours per month	Frequency	Percent of total sample
0.00	169	93.9%
0.50	1	0.6%
0.66	1	0.6%
2.00	1	0.6%
4.00	4	2.2%
6.00	2	1.1%
8.00	1	0.6%
12.00	1	0.6%
Total	180	100.0%

Chart 3.9 shows the received personal therapy of the sample in graphical form.

Chart 3.9 Received personal therapy of total sample



Due to the low frequency of use of personal therapy in the sample (6.1%), the variable was not used in any subsequent analyses.

3.3.5 Likert Stress and Impairment Scales

The data from the likert stress scale showed that 96 (53.3%) of the sample reported being at least moderately stressed by their work, with 18 (10%) feeling that they were very stressed, and two (1.1%) extremely stressed by their work.

Cushway and Tyler (1996) report how in their studies of stress and clinical psychologists, they have found that when psychologists were asked to rate to what extent they were stressed by their job, half of the sample described themselves as moderately stressed, and a quarter described themselves as very stressed. However it is not clear from their studies as to how they have combined the seven point scale to yield the reported results, and so a direct comparison is not possible.

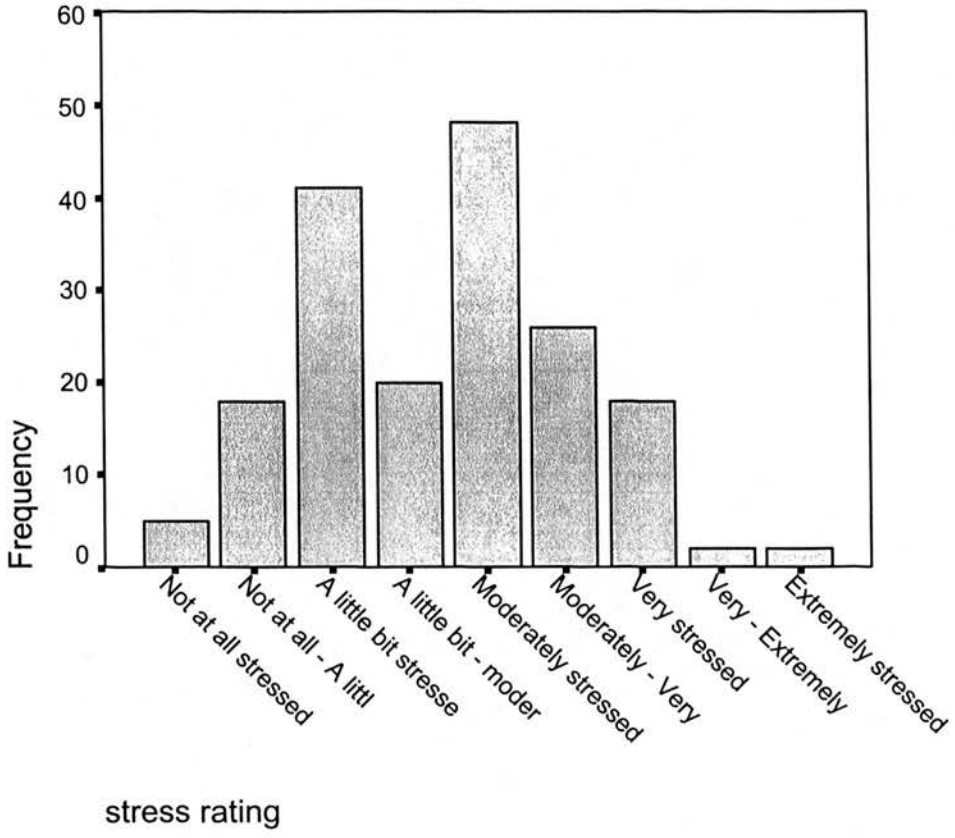
Table 3.17 summarises the results from the stress likert scale.

Table 3.17 Results of likert scale for being stressed by work

Likert category	Frequency	Percent of total sample
Not at all stressed	5	2.8%
Not at all - A little bit	18	10.0%
A little bit stressed	41	22.8%
A little bit - moderately	20	11.1%
Moderately stressed	48	26.7%
Moderately - Very	26	14.4%
Very stressed	18	10.0%
Very - Extremely	2	1.1%
Extremely stressed	2	1.1%
Total	180	100.0%

Chart 3.10 shows a graphical representation of the data from the likert scale for being stressed by work.

Chart 3.10 Results of likert scale for being stressed by work



The results from the likert scale of how much psychologists felt that the stress they experienced impaired their work showed that 36 (20%) reported feeling that their work was impaired moderately or above by the stress they experienced at work. This finding compares with Coster and Schwebel's (1997) study of impairment amongst psychologists where they found that 26% of respondents endorsed one or more items of an impairment questionnaire indicating that they experienced some form of professional impairment.

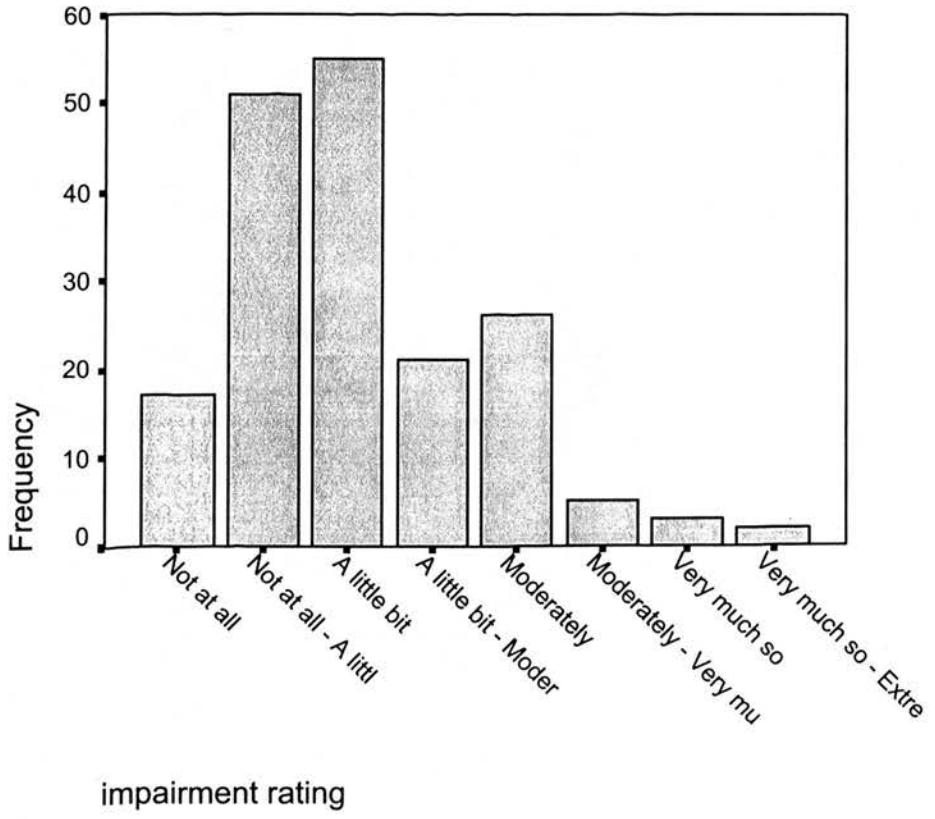
Table 3.18 summarises the results from the likert scale relating to the amount of impairment being caused by stress at work.

Table 3.18 Results of likert scale for impairment by stress

Likert category	Frequency	Percent of total sample
Not at all	17	9.4%
Not at all - A little bit	51	28.3%
A little bit	55	30.6%
A little bit - Moderately	21	11.7%
Moderately	26	14.4%
Moderately - Very much so	5	2.8%
Very much so	3	1.7%
Very much so - Extremely	2	1.1%
Total	180	100.0%

Chart 3.11 summarises the results of the likert scale for impairment by stress.

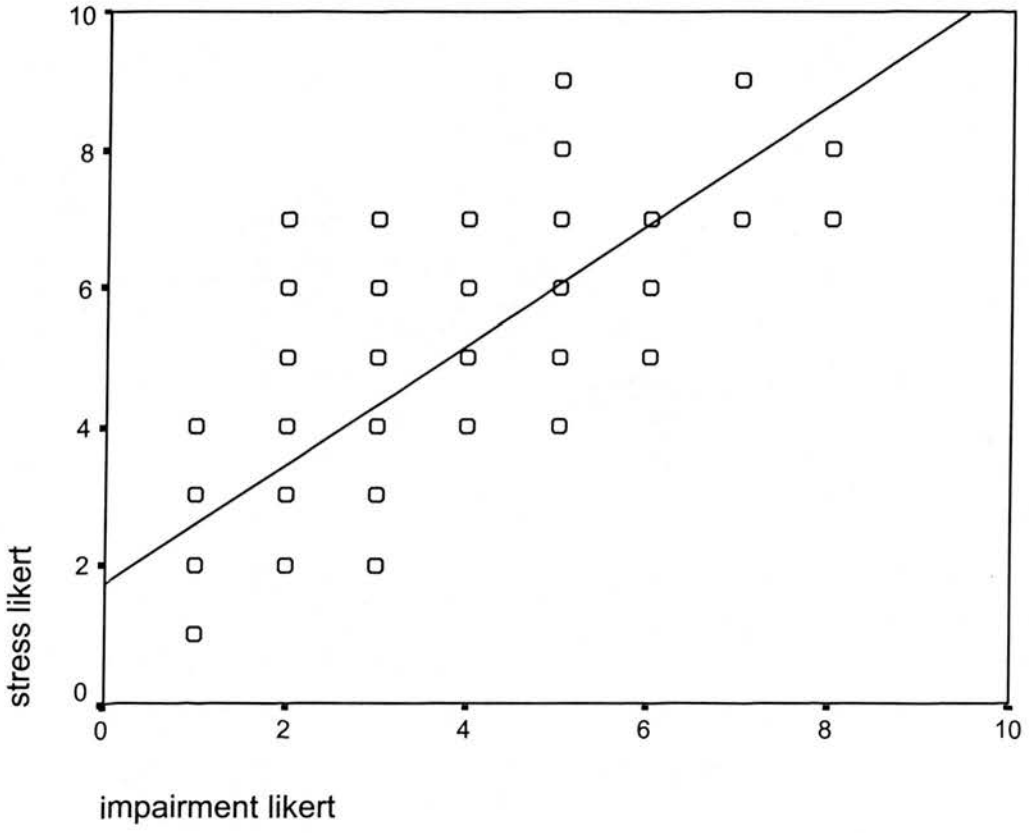
Chart 3.11 Results of likert scale for impairment by stress



A two-tailed bivariate Pearson correlation was carried out on the scores from the likert scales for stress at work, and impairment by stress to examine the association between the two scores. A moderate correlation was found between scores on the two scales ($N = 180$, $r = 0.749$, $p < 0.001$), indicating a positive association between self rated stress and self rated impairment on work.

Chart 3.12 shows a scatterplot of the two likert scale scores with linear regression line fitted. Higher scores on each axis relate to higher levels of stress and impairment.

Chart 3.12 Scatterplot of stress and impairment by stress likert scales



3.4 Results From Individual Scales

3.4.1 Mental Health Professionals Sources of Pressure Scale

The data collected on the Mental Health Professionals Sources of Pressure Scale (MHPSS) in this study allowed an analysis of the subscale reliability, and a comparison of this with previous studies examining the reliability of the scale. All of the seven subscales achieved an acceptable internal consistency with Cronbach's alphas ranging from 0.62 to 0.85. The poorest internal consistencies were obtained for the subscales of; client related difficulties (0.62), lack of resources (0.63), and home-work conflict (0.63). All other scales achieved Cronbach's alphas of over 0.8. Table 3.19 summarise the results from the reliability analysis compared with data reported in two previous reliability studies; Cushway, Tyler and Nolan (1996), and Mehrota, Rao and Subbakrishna (2000).

Table 3.19 Summary of reliability data with comparison data

	Subscale	Present study (N = 180)	Cushway *et al.* (N = 145)	Mehrota *et al.* (N = 116)
Cronbach's Alphas	Workload	0.83	0.77	0.77
	Client –related difficulties	0.62	0.74	0.64
	Organisational structure and processes	0.85	0.81	0.75
	Relationships and conflicts with other professionals	0.81	0.77	0.80
	Lack of resources	0.63	0.60	0.71
	Professional self-doubt	0.81	0.87	0.70
	Home-work conflict	0.63	0.61	0.67
	MHPSS total	0.89	0.87	0.89
Pearson's *r*	Average subscale intercorrelation	0.29	0.25	-
	Range of subscale intercorrelations	0.05 - 0.62	-0.03 - 0.67	-

It can be seen from the table that in Cushway *et al.*'s (1996) study of the development of the MHPSS they also found that the subscales of lack of resources and home-work conflict achieved the lowest internal consistency, whereas Mehrota *et al.*'s (2000) validation study achieved lowest consistency scores for client-related difficulties and home-work conflict. The data from the present study is therefore comparable with previous reliability studies both in terms of overall reliability confirmation, and in the relative reliabilities of the subscales.

An examination of responses to the MHPSS showed that of the various subscales, the highest scores were obtained on the workload subscale, with the organisational structure and processes, and lack of resources subscales being the next highest scoring subscales.

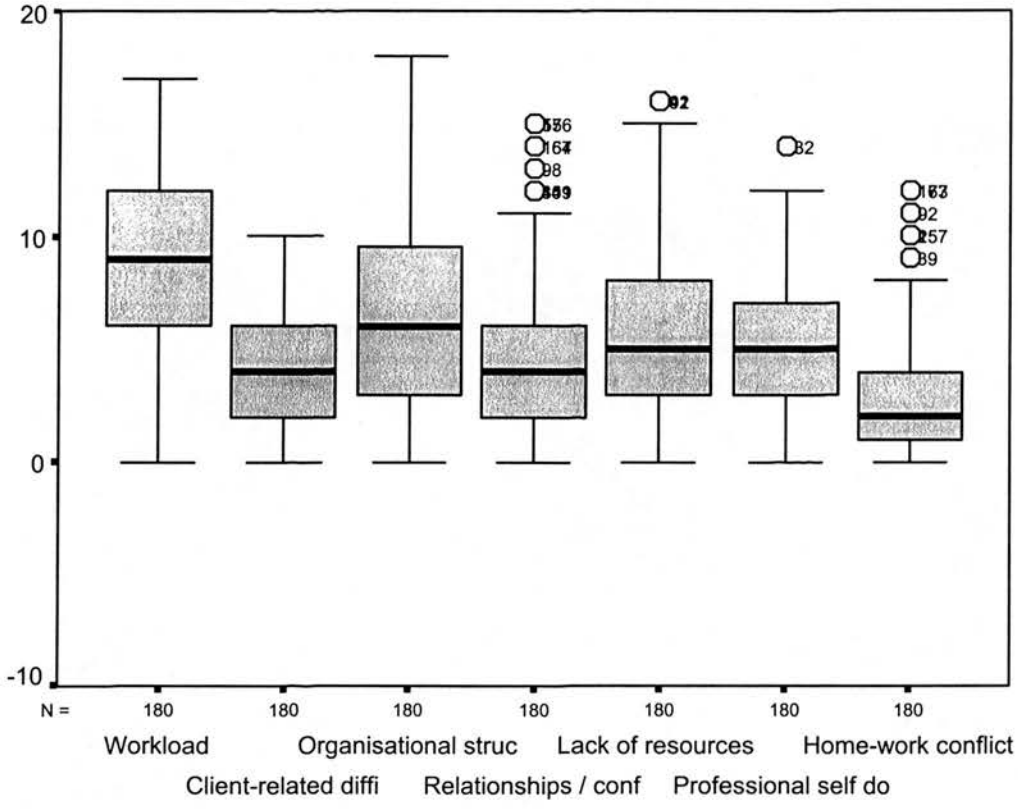
Table 3.20 summarises the MHPSS data with the results from Cushway *et al.*'s (1996) study for comparison.

Table 3.20 MHPSS subscale and total scores for total sample with comparison

	Present study (N = 180)		Cushway *et al.* (N = 154)
Subscale	Mean subscale score	Standard deviation	Mean subscale score
Workload	8.84	4.11	10.80
Client-related difficulties	3.89	2.29	5.82
Organisational structure and processes	6.33	4.49	8.22
Relationships and conflicts with other professionals	4.17	3.36	5.40
Lack of resources	5.72	3.24	6.54
Professional self-doubt	4.90	2.96	7.26
Home-work conflict	2.94	2.52	5.16
MHPSS total	36.78	14.66	49.14

Chart 3.13 shows a boxplot of the mean subscale scores on the MHPSS for the total sample.

Chart 3.13 Boxplot for mean MHPSS subscale scores for total sample

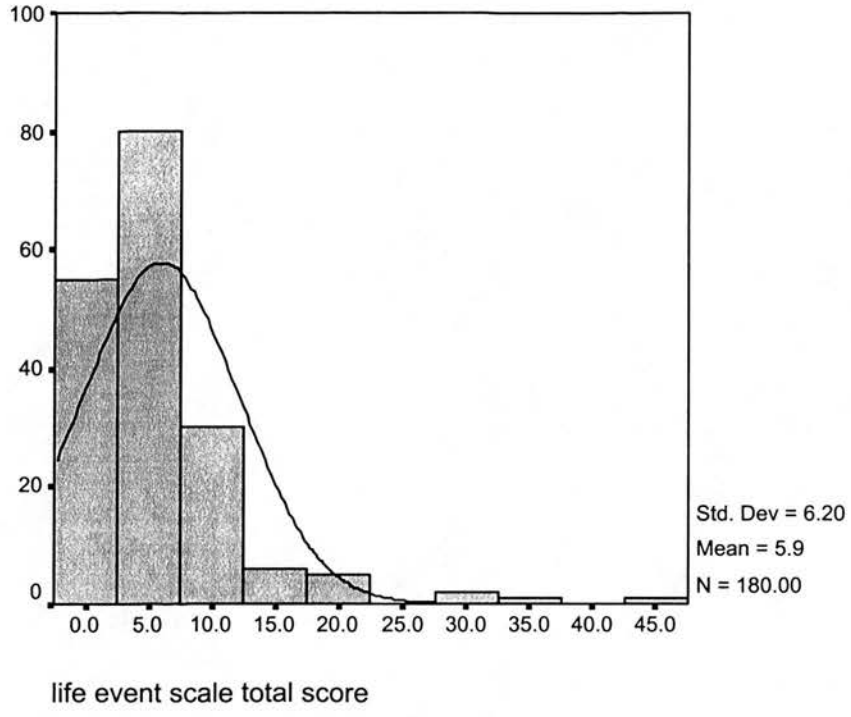


Comparison of the average MHPSS subscale and total scale scores with Cushway *et al.*'s (1996) findings shows that across all scales the present study's data are somewhat lower than those reported in the Cushway *et al.* sample, however without full details of the Cushway *et al.* data it is unclear if there is a significant difference between the subscale and total scale means for the two samples.

3.4.2 Life Events Scale

The mean score on the life events scale (LES) for the total sample was 5.93 (s.d. = 6.19), with a minimum score of 0.00 and a maximum of 45.00. Chart 3.14 shows the distribution of LES scores for the total sample.

Chart 3.14 Total life event scale score for total sample



The life event data showed a skewness value of 2.91 and a kurtosis value of 12.21 and was therefore transformed prior to analysis. The data was transformed using the equation of log (x+1) which produced skewness and kurtosis values of –0.18 and 0.06 respectively.

3.4.3 Social Support Scale

Table 3.21 summarises the mean scores for the social support subscales. For each support scale the total possible score is 14, while for discrepancy scores the maximum score is 12. Data from a study involving 44 undergraduate students is presented for comparison (from McCarthy, B., unpublished data).

Table 3.21 Mean social support scores for total sample

	Present study (N=180)		McCarthy (N=44)
	Mean	Standard deviation	Mean
Actual emotional support	9.43	1.77	8.4
Actual practical support	8.63	1.94	8.6
Ideal emotional support	11.08	1.34	10.8
Ideal practical support	10.34	1.58	10.0
Emotional support discrepancy	1.65	1.25	2.4
Practical support discrepancy	1.71	1.36	1.8

The comparative data suggests that the scores obtained in the present study are comparable with previously reported data.

3.4.4 Professional support scale

No comparative data were available for the use of the Significant Others Scale for professional support.

Table 3.22 summarises the mean scores for the professional support subscales.

Table 3.22 Mean professional support scores for total sample

	Present study (N=180)	
	Mean	Standard deviation
Actual emotional support	8.76	2.15
Actual practical support	7.99	2.34
Ideal emotional support	10.41	2.17
Ideal practical support	9.80	2.29
Emotional support discrepancy	1.65	1.39
Practical support discrepancy	1.81	1.57

A comparison between the mean scores for professional support and those for social support shows a similar magnitude and pattern for each subscale.

3.4.5 Ways of Coping Scale

Due to the various methods of categorising coping behaviours present in the literature and discussed in the introduction, a reliability analysis was carried out on the data obtained from the present study on the emotion focused / problem focused split of the ways of coping (WCQ) questionnaire. The reliability analysis showed that the two scales achieved acceptable levels of internal consistency with Cronbach's alphas of 0.73 and 0.77. Table 3.23 shows reliability data for the WCQ questionnaire.

Table 3.23 Reliability data for the ways of coping questionnaire

	Subscale	Present study (N = 180)
Cronbach's Alphas	Emotion focused	0.73
	Problem focused	0.77

The mean score for emotion focused items for the total sample was 0.8 (s.d. = 0.33), while the mean score for problem focused items was 1.5 (s.d. = 0.49). A post-hoc paired samples t-test for equality of means with an alpha set at 0.01, showed that

mean scores for problem focused items were higher than those for emotion focused items ($t = 18.39$, $df = 179$, $p < 0.001$), indicating that the sample endorsed problem focused ways of coping more than emotion focused.

3.4.6 General Health Questionnaire

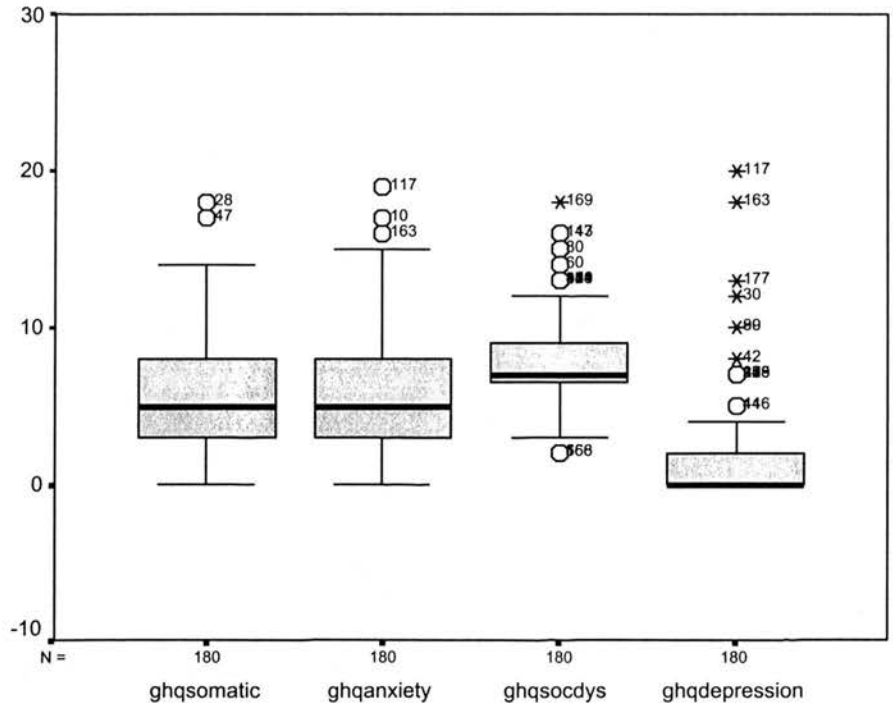
The mean likert scored subscale and total scores for the GHQ are presented in table 3.24.

Table 3.24 Mean GHQ subscale and total scores for total sample

Subscale	Somatic	Anxiety and insomnia	Social dysfunction	Depression	GHQ likert total
Mean	5.92	5.76	7.68	1.44	20.80
Standard deviation	3.64	4.01	2.61	2.96	10.37

Chart 3.15 shows a boxplot of the mean subscale scores for the GHQ for the total sample.

Chart 3.15 Boxplot of mean GHQ subscale scores for the total sample



Data for the total likert score on the GHQ showed a skewness value of 1.19 and a kurtosis value of 1.45 and was therefore transformed prior to use in analysis. The data was transformed using the equation log (x+1), which produced skewness and kurtosis values of 0.22 and –0.56 respectively.

Scoring the GHQ using the 0-0-1-1, 'GHQ' method allowed a measure of just significant clinical caseness to be obtained. The data showed that 37.8% of the sample scored above cut off for 'caseness'. Table 3.25 summarises the GHQ 'caseness' data for the total sample.

Table 3.25 Summary of GHQ caseness data for total sample

	Frequency	Percent of total sample
GHQ Non-case	112	62.2%
GHQ Case	68	37.8%
Total	180	100.0%

This figure of 37.8% caseness is lower than the 59% reported in a sample of trainee clinical psychologists by Cushway (1992), but comparable with the rates of 24%, 29.4%, and 40% in samples of qualified clinical psychologists reported by Darongkamas *et al.* (1994), Cushway and Tyler (1994), and Cushway *et al.* (1996) respectively. Sampson (1990) in a directly comparable study of clinical psychologists in Scotland found a caseness level of 33%, slightly lower than in the present study.

3.5 Testing of Hypotheses

3.5.1 Male / Female Differences

The first hypothesis predicted, in line with previous research findings that females would have higher mean GHQ scores than males. Means on the MHPSS and Life Event Scale were also compared between males and females.

An independent samples t-test for equality of means between males and females on the above variables showed that there were no significant differences between the two groups on any of the variables. Table 3.26 summarises the results from of the t-test analyses for this hypothesis.

Table 3.26 Summary of t-test results for male / female differences

	Male		Female		t-test for equality of means		
Measure	Mean	Standard deviation	Mean	Standard deviation	t	df	Significance (2-tailed)
GHQ total	2.97	0.44	2.98	0.45	0.194	178	0.846
LES total	1.44	0.66	1.69	0.83	1.802	178	0.073
MHPSS total	36.44	14.87	36.89	14.65	0.175	178	0.862

3.5.2 Single / With Partner Differences

The second hypothesis predicted that those psychologists in a partnership would have lower scores on the measures of life and work stressors, and on the GHQ. Independent samples t-tests for equality of means showed that there were no significant differences between the two groups on any of the measures. Table 3.27 summarises the results of the t-test analyses for this hypothesis.

Table 3.27 Summary of t-test results for single / with partner differences

	Single		With partner		t-test for equality of means		
Measure	Mean	Standard deviation	Mean	Standard deviation	t	df	Significance (2-tailed)
GHQ total	3.01	0.44	2.97	0.45	0.539	178	0.590
LES total	1.77	0.89	1.59	0.77	1.243	178	0.215
MHPSS total	40.15	14.01	35.79	14.75	1.680	178	0.95

3.5.3 Supervised / Non-supervised Differences

The third hypothesis predicted that those receiving supervision would have lower scores on the MHPSS and the GHQ. An independent samples t-test for equality of means showed no significant differences between the two groups on either dependent variable. Table 3.28 summarises the results of the t-test analyses for this hypothesis.

Table 3.28 Summary of t-test results for supervised / non-supervised differences

	Supervised		Non-supervised		t-test for equality of means		
Measure	Mean	Standard deviation	Mean	Standard deviation	t	df	Significance (2-tailed)
GHQ total	2.97	0.44	2.99	0.46	0.256	178	0.798
MHPSS total	35.12	14.59	38.41	14.63	1.507	178	0.134

3.5.4 Associations Between Work Impairment and Outcomes

The fourth hypothesis predicted that scores on the professional impairment likert scale would show a positive association with GHQ and MHPSS total scores. A two-tailed bivariate Pearson correlation showed significant moderate positive correlations between impairment scores and total GHQ scores ($N = 180$, $r = 0.524$, $p < 0.001$) and between impairment and total MHPSS scores ($N = 180$, $r = 0.527$, $p < 0.001$). Charts 3.16 and 3.17 show scatterplots of the impairment and outcome data with regression lines fitted.

Chart 3.16 Scatterplot of impairment and total GHQ scores

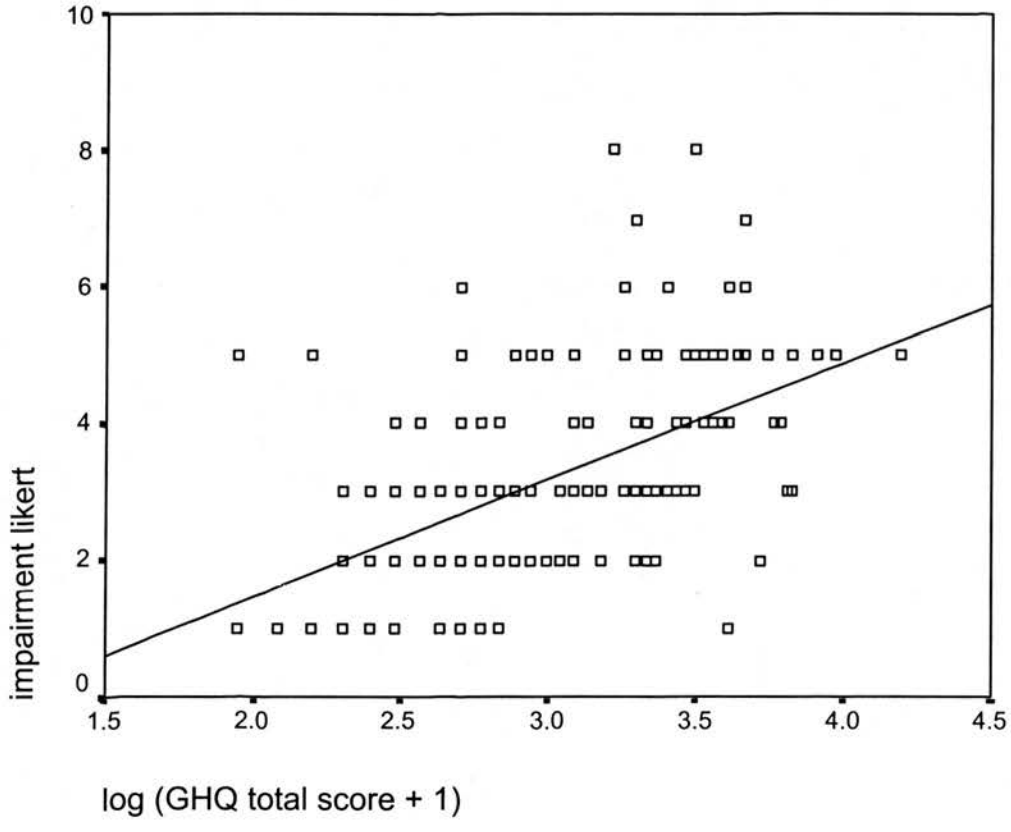
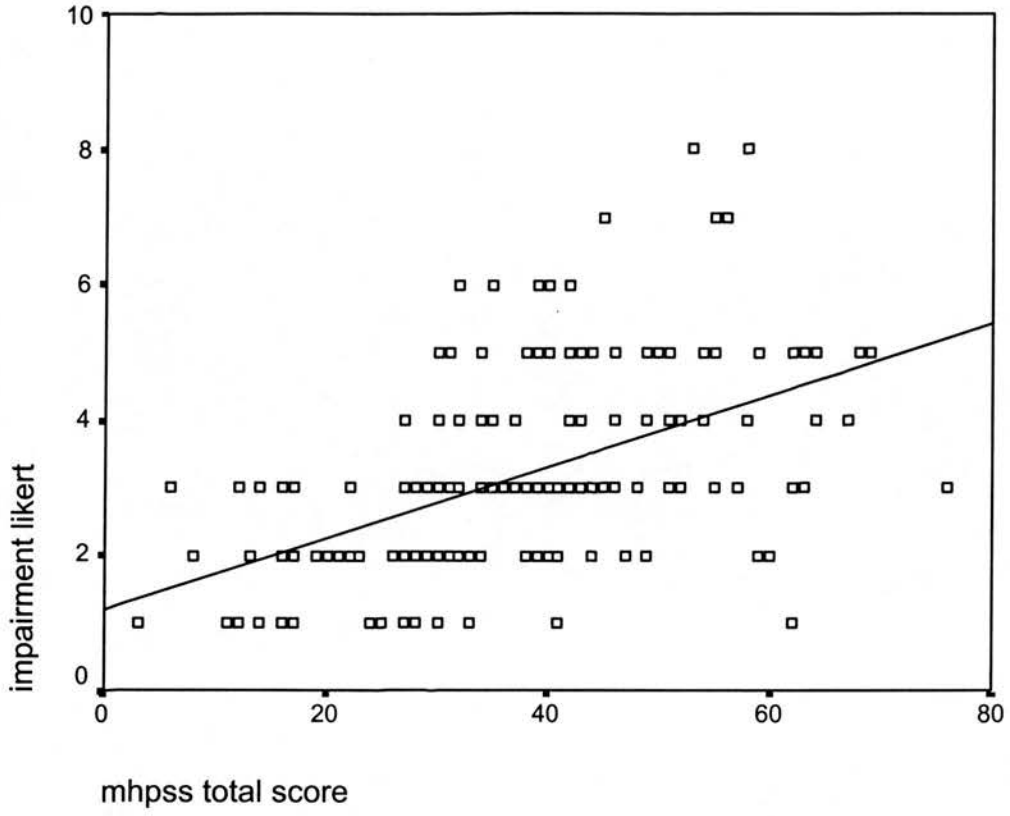


Chart 3.17 Scatterplot of impairment and total MHPSS scores



3.5.5 Associations Between Descriptive Variables and Outcomes

The fifth hypothesis predicted that the values of various descriptive variables would be associated with scores on the MHPSS and the GHQ. Specifically it was hypothesised that the variables of; hours worked per week, and hours of supervision provided would be positively correlated with the MHPSS and the GHQ scores, while the values of the variables of; age, years since qualification, hours of continued professional development per month, and hours of received supervision would be negatively correlated with MHPSS and GHQ scores.

Two-tailed Pearson correlations were used to examine the intervariable associations. Only one significant correlation was found with a weak positive correlation being found between hours of provided supervision and total MHPSS score. It was however noted that correlations between received supervision and work hours per week and the outcome variables approached significance in the predicted direction. Table 3.29 summarises the results of the intervariable correlations.

Table 3.29 Correlations between descriptive variables and outcomes

	GHQ total			MHPSS total		
	r	Significance	N	r	Significance	N
Provided supervision hours per month	0.134	0.073	180	0.163	0.029	180
Work hours per week	0.102	0.175	180	0.128	0.088	180
Age	0.028	0.707	180	-0.002	0.976	180
Years since qualification	0.001	0.991	180	-0.015	0.840	180
CPD hours per month	0.033	0.658	180	-0.09	0.191	180
Received supervision hours per month	-0.011	0.880	180	-0.140	0.061	180

3.5.6 Association Between Work Stressors and Well Being

The sixth hypothesis predicted that there would be positive associations between levels of work stressors as measured by the MHPSS, and psychopathology as measured by the GHQ. In two sets of two tailed Pearson correlations, total MHPSS scores were correlated with subscale and total scores for the GHQ, and total GHQ scores were correlated with subscale and total scores for the MHPSS. Table 3.30 shows results from the first set of correlations.

Table 3.30 Correlations between total MHPSS and GHQ total and subscales

		MHPSS total
GHQ total score	r	0.426
	Significance	0.001
	N	180
GHQ somatic subscale	r	0.368
	Significance	0.001
	N	180
GHQ anxiety subscale	r	0.441
	Significance	0.001
	N	180
GHQ social dysfunction subscale	r	0.161
	Significance	0.031
	N	180
GHQ depression subscale	r	0.309
	Significance	0.001
	N	180

The results show a range of weak to moderate significant correlations between total MHPSS scores and all the total and subscale scores of the GHQ.

Table 3.31 shows results from the second set of correlations.

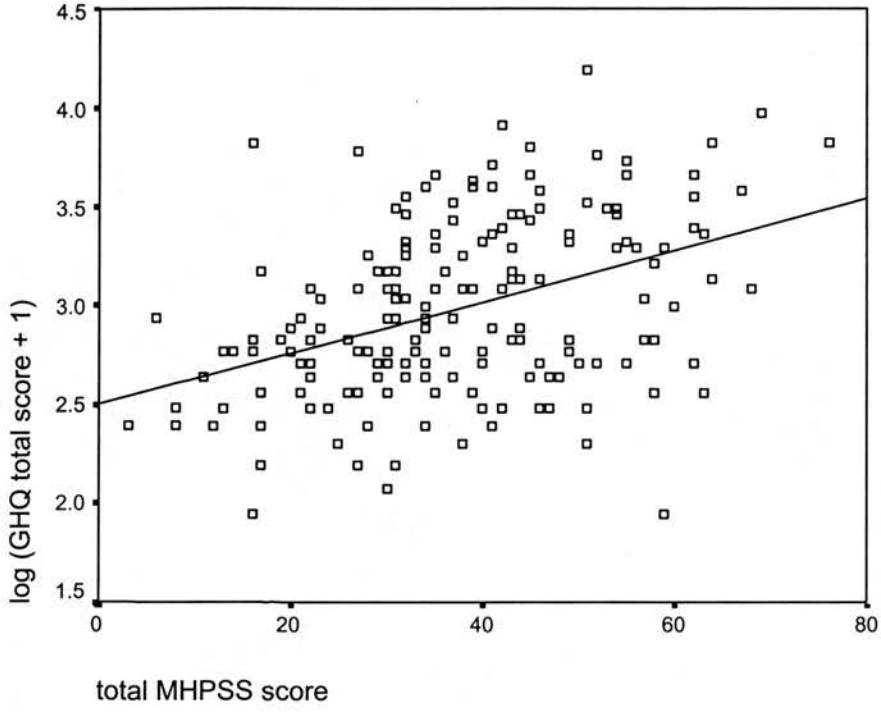
Table 3.31 Correlations between total GHQ and MHPSS total and subscales

		Total GHQ score
MHPSS workload subscale	r	0.309
	Significance	0.001
	N	180
MHPSS client-related difficulties subscale	r	0.181
	Significance	0.015
	N	180
MHPSS organisational structure subscale	r	0.316
	Significance	0.001
	N	180
MHPSS relationships / conflicts with other professionals subscale	r	0.171
	Significance	0.022
	N	180
MHPSS lack of resources subscale	r	0.247
	Significance	0.001
	N	180
MHPSS professional self doubt subscale	r	0.280
	Significance	0.001
	N	180
MHPSS home-work conflict subscale	r	0.373
	Significance	0.001
	N	180
MHPSS total score	r	0.426
	Significance	0.001
	N	180

The results again show a range of weak to moderate significant correlations between total GHQ scores and all of the subscales of the MHPSS, as well as with MHPSS total score.

The results also show a significant moderate correlation between GHQ total scores and MHPSS total scores ($N = 180$, $r = 0.426$, $p < 0.001$). Chart 3.18 shows the scatterplot of GHQ and MHPSS total scores.

Chart 3.18 Scatterplot of total GHQ and MHPSS scores



3.5.7 Association Between Life Events and Well Being

The seventh hypothesis predicted that there would be a positive association between total life event scores and total scores on the GHQ.

A set of two-tailed Pearson correlations were carried out between total life event scores and scores for all the subscales and total score of the GHQ.

The results show moderate significant correlations between life event total scores and GHQ total, anxiety and depression scores. A weak significant correlation was found between life event total and the GHQ somatic subscale, but no significant correlation with the social dysfunction subscale.

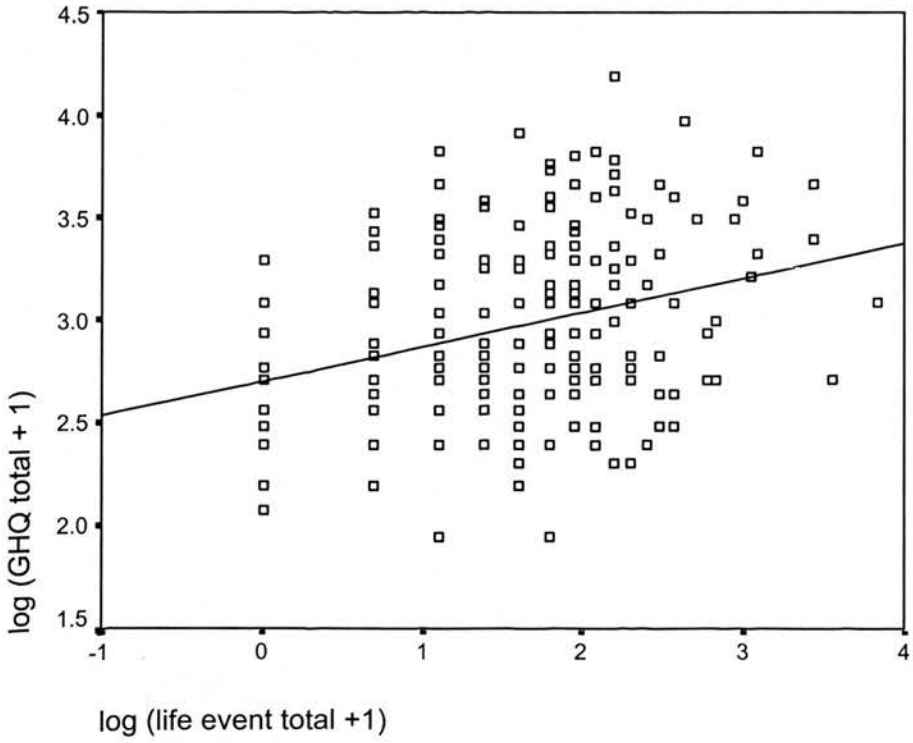
Table 3.32 shows the data from the life event and GHQ correlations.

Table 3.32 Correlations between life event scores and GHQ total and subscales

		Total life event scores
GHQ somatic subscale	r	0.190
	Significance	0.011
	N	180
GHQ anxiety subscale	r	0.3301
	Significance	0.001
	N	180
GHQ social dysfunction subscale	r	0.051
	Significance	0.495
	N	180
GHQ depression subscale	r	0.302
	Significance	0.001
	N	180
GHQ total score	r	0.301
	Significance	0.001
	N	180

Chart 3.19 shows a scatterplot of life event and GHQ total scores.

Chart 3.19 Scatterplot of life event and GHQ total scores



3.5.8 Associations Between Measures of Support and Well Being

The eighth hypothesis predicted that measures of both social and professional support would be associated with GHQ scores. Specifically it was predicted that measures of perceived emotional support, practical support, and reported support network size would be negatively correlated with GHQ scores, while measures of discrepancy in emotional and practical support would be positively correlated with GHQ scores. Two-tailed Pearson correlations were carried out between the support measures and GHQ total scores.

3.5.8-1 Social Support

No significant correlation was found between social support network size and GHQ scores ($N = 180$, $r = -0.054$, $p = 0.469$ ns).

Table 3.33 shows the results of the correlations between social support measures and GHQ scores.

Table 3.33 Correlations between social support scores and GHQ scores

Social support		Total GHQ score
Average actual emotional support	r	-0.140
	Significance	0.060
	N	180
Average actual practical support	r	-0.250
	Significance	0.001
	N	180
Average emotional support discrepancy	r	0.149
	Significance	0.046
	N	180
Average practical support discrepancy	r	0.334
	Significance	0.001
	N	180

The results show weak to moderate significant correlations in the predicted direction for measures of perceived practical support, and discrepancies in emotional and

practical support. A weak negative correlation that approached significance was also noted between perceived emotional support and GHQ score.

3.5.8-2 Professional Support

No significant correlation was found between reported professional support network size and GHQ score (N = 180, r = 0.070, p = 0.353 ns).

Table 3.34 shows the results of the correlations between professional support measures and GHQ scores.

Table 3.34 Correlations between professional support scores and GHQ scores

Professional support		Total GHQ score
Average actual emotional support	r	-0.135
	Significance	0.071
	N	180
Average actual practical support	r	-0.156
	Significance	0.037
	N	180
Average emotional support discrepancy	r	0.144
	Significance	0.054
	N	180
Average practical support discrepancy	r	0.148
	Significance	0.047
	N	180

The results show weak significant correlations between perceived practical support and discrepancy in practical support in the predicted directions. Again measures of emotional support and emotional support discrepancy approached significance in their associations with GHQ scores in the predicted directions.

3.5.9 Associations Between Measures of Support and Stressors

The ninth hypothesis predicted that measures of support would be associated with measures of stressors (MHPSS and LES). Specifically it was hypothesised that measures of perceived emotional and practical support, and total network size would be negatively correlated with scores on stressor scales, while discrepancy scores for emotional and practical support would be positively correlated with stressor scores. Furthermore it was predicted that social support and professional support would exert greater effects upon life events and work stressors respectively. Two-tailed Pearson correlations were carried out between the support measures and the MHPSS and LES scale total scores.

3.5.9-1 Social Support

No significant association was found between total network size and either LES total ($N = 180$, $r = 0.118$, $p = 0.116$ ns), or MHPSS total ($N = 180$, $r = 0.122$, $p = 0.102$ ns). Table 3.36 shows the correlations between measures of social support and MHPSS and LES scores.

Table 3.36 Correlations between social support scores and stressor scores

Social support		LES total	MHPSS total
Average actual emotional support	r	-0.129	-0.072
	Significance	0.084	0.338
	N	180	180
Average actual practical support	r	-0.186	-0.237
	Significance	0.012	0.001
	N	180	180
Average emotional support discrepancy	r	0.157	0.125
	Significance	0.035	0.095
	N	180	180
Average practical support discrepancy	r	0.198	0.306
	Significance	0.008	0.001
	N	180	180

The results show weak to moderate significant correlations between perceived practical support and discrepancy in that support with both LES and MHPSS scores in the predicted direction. A weak significant correlation was also found between discrepancy in emotional support and LES total.

3.5.9-1 Professional Support

Weak to moderate significant correlations were found between total professional support network size and scores on the MHPSS ($N = 180$, $r = 0.227$, $p = 0.002$), and on the LES ($N = 180$, $r = 0.214$, $p = 0.004$). The observed correlations were found in the opposite direction to that predicted, with higher network sizes being associated with higher MHPSS and LES scores. Table 3.36 shows the correlations between measures of professional support and MHPSS and LES scores.

Table 3.36 Correlations between professional support scores and stressor scores

Professional support		LES total	MHPSS total
Average actual emotional support	r	-0.110	-0.095
	Significance	0.142	0.206
	N	180	180
Average actual practical support	r	-0.044	-0.181
	Significance	0.553	0.015
	N	180	180
Average emotional support discrepancy	r	0.127	0.310
	Significance	0.089	0.001
	N	180	180
Average practical support discrepancy	r	0.080	0.337
	Significance	0.286	0.001
	N	180	180

The results show weak to moderate significant correlations between perceived practical support and discrepancies in emotional and practical support and MHPSS

totals, but no significant correlations between measures of professional support and LES scores.

Examination of the two sets of results suggests that perceived support and satisfaction with support is associated with experience of life and work stressors, and that while social support influences the experience of life and work stressors, professional support only influences the experience of work stressors.

3.5.10 Associations Between Ways of Coping and Well Being

Hypothesis ten predicted that the use of emotion focused ways of coping would be associated with poorer well being while the use of problem focused ways of coping would predict better well being.

Pearson correlations were used to examine the relationship between mean scores on the WCQ scale and scores on the GHQ subscales and total score. Table 3.37 summarises the results of these correlations.

Table 3.37 Correlations between ways of coping and GHQ scores

Way of coping		GHQ somatic subscale	GHQ anxiety subscale	GHQ social dysfunction subscale	GHQ depression subscale	GHQ total
Emotion focused	r	0.129	0.242	0.103	0.256	0.222
	Significance	0.085	0.001	0.168	0.001	0.003
	N	180	180	180	180	180
Problem focused	r	0.048	0.132	-0.034	0.019	0.060
	Significance	0.521	0.078	0.648	0.800	0.423
	N	180	180	180	180	180

The results show weak to moderate significant correlations between scores for emotion focused coping and scores on the anxiety, depression, and total GHQ scales in the predicted direction. No significant correlations were found between problem focused coping and GHQ scores.

3.5.11 Stressor, Support and Well Being Interactions

The eleventh hypothesis predicted that measures of support would moderate the relationships between stressors and reported well being. Specifically it was predicted that social support measures would moderate any life event / well being relationship, while measures of professional support would moderate any works stressor / well being relationship.

As a crude measure of this buffering hypothesis of support, the eight support variables and two stressor variables (LES, MHPSS) were dichotomised on the basis of median split to produce two factors for each (high / low support, and high / low experience of stressors).

For a test of the buffering hypothesis of social support the two factors for each support variable and the two factors for the life stressors scale were entered into a two way ANOVA with GHQ total as the dependent variable.

For professional support the two life event factors were replaced with the two MHPSS factors and again entered into a two way ANOVA with GHQ total as the dependent variable..

Evidence for the buffering hypothesis in each case would be provided by significant interactions between the dichotomised variables and the dependent variable of GHQ total.

No significant interactions were found even though all the various combinations of support and stress variables were used. As such the data reported in this study did not provide any confirmatory evidence for a buffering effect of support.

Summaries of the analyses are presented in appendix 15.

3.5.12 Regression Analyses

Regression analyses were carried out to determine the relative influence of the measured independent variables on the primary dependent variable of reported well being (GHQ total). A second regression analysis, consequent to the results of the first analysed the relative influence of the measured variables upon the variance in experiences of stressors at work (MHPSS total scores).

3.5.12-1 GHQ Regression Analysis

A linear regression analysis was first carried out using the enter method, where all independent variables are forced into the regression model to determine their relative influence upon the dependent variable. To confirm the results of the first regression, a forward stepwise regression was then carried out. Table 3.38 shows the results of the stepwise regression analysis.

Table 3.37 Results of GHQ regression analysis (enter method)

Dependent variable = GHQ total

	Unstandardized coefficients		Standardized coefficients	Significance
	B	Standard error	Beta	p
(Constant)	2.417	0.407		0.001
LES total	0.101	0.042	0.179	0.017
WCQ problem focused	0.001	0.068	0.008	0.915
WCQ emotion focused	0.112	0.107	0.082	0.297
Age in years	0.007	0.008	0.159	0.327
Years of practice	-0.008	0.007	-0.176	0.276
Work hours per week	0.004	0.003	0.083	0.252
Received supervision hours per month	0.019	0.016	0.085	0.237
Provided supervision hours per month	-0.000	0.005	0.000	0.996
Continuing professional development hours per month	0.008	0.007	0.079	0.254
Social support network size	-0.014	0.013	-0.090	0.265
Professional support network size	-0.002	0.014	-0.013	0.879
MHPSS total	0.009	0.003	0.316	0.001
Average actual emotional support (social support)	-0.056	0.034	-0.219	0.106
Average actual practical support (social support)	0.036	0.030	0.158	0.223
Average emotional support discrepancy (social support)	-0.069	0.045	-0.194	0.120
Average practical support discrepancy (social support)	0.118	0.039	0.358	0.003
Average actual emotional support (professional support)	0.001	0.029	0.006	0.964
Average actual practical support (professional support)	-0.023	0.029	-0.122	0.425
Average emotional support discrepancy (professional support)	0.002	0.041	0.008	0.949
Average practical support discrepancy (professional support)	-0.027	0.038	-0.095	0.474

Table 3.38 Results of GHQ regression analysis (forward stepwise method)

Dependent variable = GHQ total

Model		Unstandardized coefficients		Standardized coefficients	Significance
		B	Standard error	Beta	p
1	(Constant)	2.501	0.082		0.001
	MHPSS total	0.013	0.002	0.426	0.001
2	(Constant)	2.451	0.081		0.001
	MHPSS total	0.011	0.002	0.357	0.001
	Average practical support discrepancy (social support)	0.074	0.023	0.225	0.001
3	(Constant)	2.342	0.090		0.001
	MHPSS total	0.009	0.002	0.319	0.001
	Average practical support discrepancy (social support)	0.066	0.023	0.201	0.004
	LES total	0.102	0.038	0.181	0.008

In the first regression analysis the only variables which showed significant contributions to the variance in the outcome measure were; MHPSS total score, Life Event total score, and discrepancy in practical social support, with higher values on all predicting higher GHQ scores.

The forward stepwise regression analysis confirmed this result with the three variables being the only ones to survive the stepwise regression. The stepwise regression also confirmed the relative degree to which these variables contributed to the variance of the outcome measure, with MHPSS total accounting for the greatest amount, followed by discrepancy in practical social support, and finally Life Event total score.

3.5.12-2 MHPSS Regression Analysis

As discussed in the introduction the relationship between well being and experienced stressors can be thought of as a bi-directional relationship. However, assuming that in the relationship between work stressors and well being the direction of causality is more heavily weighted in the stressor to well being direction, it is a potentially important finding that MHPSS scores were the strongest predictor for scores on the GHQ.

In line with this model and in an effort to determine what factors most account for experience of stressors at work (amongst the measured variables) a second set of regression analyses were carried out with MHPSS total scores as the dependent variable.

As before the first regression analysis was carried out using the enter method where all measured variables, apart from GHQ total and subscale scores, were entered into the regression equation. A second regression used the forward stepwise method to confirm and elaborate upon the findings from the first analysis.

Table 3.39 summarises the results from the first of these analyses.

Table 3.39 Results of MHPSS regression analysis (enter method)

Dependent variable = MHPSS total

	Unstandardized coefficients		Standardized Coefficients	Significance
	B	Standard error	Beta	p
(Constant)	22.343	14.107		0.115
Age in years	-0.067	0.240	-0.044	0.778
Years of practice	-0.005	0.225	-0.004	0.980
Work hours per week	0.298	0.107	0.190	0.006
Continuing professional development hours per month	-0.222	0.209	-0.069	0.292
Social support network size	0.063	0.405	0.012	0.876
Professional support network size	1.041	0.450	0.185	0.022
Average actual emotional support (social support)	0.225	1.070	0.027	0.834
Average actual practical support (social support)	-0.726	0.935	-0.096	0.439
Average emotional support discrepancy (social support)	-0.406	1.403	-0.034	0.773
Average practical support discrepancy (social support)	1.462	1.206	0.136	0.227
Average actual emotional support (professional support)	1.179	0.908	0.173	0.196
Average actual practical support (professional support)	-1.646	0.900	-0.262	0.069
Average emotional support discrepancy (professional support)	1.461	1.271	0.139	0.252
Average practical support discrepancy (professional support)	0.455	1.173	0.049	0.699
WCQ emotion focused	12.729	3.181	0.284	0.001
WCQ problem focused	1.048	2.123	0.035	0.622
Received supervision hours per month	0.210	3.998	0.010	0.958
Provided supervision hours per month	-7.339	3.978	-0.328	0.067
LES total	1.672	1.292	0.091	0.198

Table 3.40 summarises the results from the second regression analysis.

Table 3.40 Results of MHPSS regression analysis (forward stepwise method)

Dependent variable = MHPSS total

Model		Unstandardized Coefficients		Standardized coefficients	Significance
		B	Standard error	Beta	p
1	(Constant)	24.777	2.653		0.001
	WCQ emotion focused	15.490	3.155	0.345	0.001
2	(Constant)	19.956	2.695		0.001
	WCQ emotion focused	14.730	2.979	0.328	0.001
	Average practical support discrepancy (professional support)	2.993	0.622	0.320	0.001
3	(Constant)	14.771	3.163		0.001
	WCQ emotion focused	14.370	2.918	0.320	0.001
	Average practical support discrepancy (professional support)	2.882	0.610	0.308	0.001
	Professional support network size	1.089	0.367	0.193	0.003
4	(Constant)	26.368	5.518		0.001
	WCQ emotion focused	14.441	2.874	0.322	0.001
	Average practical support discrepancy (professional support)	2.478	0.621	0.265	0.001
	Professional support network size	1.105	0.362	0.196	0.003
	Average actual practical support (social support)	-1.275	0.501	-0.168	0.012
5	(Constant)	16.990	6.447		0.009
	WCQ emotion focused	15.571	2.855	0.347	0.001
	Average practical support discrepancy (professional support)	2.438	0.610	0.260	0.001
	Professional support network size	1.039	0.356	0.184	0.004
	Average actual practical support (social support)	-1.342	0.493	-0.177	0.007
	Work hours per week	0.269	0.100	0.171	0.008

The first regression analysis showed that only three variables reached significance in the prediction of MHPSS total score. The first of these was the measure of emotion

focused coping, with higher scores on this predicting higher MHPSS scores. The second variable was professional network size with, contrary to prediction, greater network size predicting higher MHPSS scores. The final variable was work hours per week, with greater number of hours predicting higher MHPSS scores.

Within the stepwise regression five variables survived as significant predictors. These included the three variables from the enter regression, as well as two others of; average discrepancy in professional practical support (high scores predicting high MHPSS scores), and average actual practical social support (low scores predicting high MHPSS scores).

In terms of relative predictive value, emotion focused coping scores was the strongest predictor with satisfaction with professional support and professional support network size the next most powerful. Perceived practical social support was the next most predictive, with work hours per week being the weakest significant predictor.

3.5.13 Qualitative Stress Data

The first open ended question asked psychologists to describe what one or two things caused them the most stress at work. Table 3.41 summarises the categorised responses to that question.

Table 3.41 Responses to 'causes of stress' question

Category	N	Percent of total sample
Clinical workload	58	32.2%
Management issues	48	26.7%
Lack of time for demands	41	22.8%
Waiting list pressure	35	19.4%
Interdisciplinary issues / conflicts	28	15.6%
Impact of patients	24	13.3%
Administration / paperwork	21	11.7%
Lack of practical resources	20	11.1%
Relationships with other colleagues	18	10%
Lack of staff	17	9.4%
Treatment issues	12	6.7%
Multiple responsibilities	8	4.4%
Lack of supervision	7	3.9%
Lack of general support	6	3.3%
Personal difficulties	5	2.8%
Lack of respect	5	2.8%
Home / work conflict	4	2.2%
Political issues	4	2.2%
Travel	3	1.7%
Meetings	3	1.7%
Concerns about colleagues	3	1.7%
Problems in self management	2	1.2%
Scientific focus	2	1.2%
Unrealistic expectations	2	1.2%
Low job satisfaction	1	0.6%
Inappropriate referrals	1	0.6%
Supervising	1	0.6%

The second open ended question asked psychologists what one or two things they thought would reduce stress at work. The categorised responses to this questions are shown in table 3.42.

Table 3.42 Responses to 'reduce stress' question

Category	N	Percent of total sample
More staff / psychologists	52	28.9%
Increase in professional support	42	23.3%
Improved management	38	21.1%
Reduction in clinical workload	28	15.6%
Increase in practical resources	26	14.4%
Increased time for cases	21	11.7%
Better interdisciplinary organisation	17	9.4%
Increased administrative support	15	8.3%
More respect / autonomy	8	4.4%
Removal of colleague	8	4.4%
Better personal management	8	4.4%
Decrease in admin. / audit	6	3.3%
Increase in training	5	2.8%
Being valued	5	2.8%
Improved contractual factors	5	2.8%
Reduction in meetings / committees	4	2.2%
More eclectic philosophy	3	1.7%
Personal development	2	1.2%
Retirement	2	1.2%
More realistic expectations	2	1.2%
New job	1	0.6%
Increased exercise / leisure	1	0.6%

Charts 3.20 and 3.21 show the response data in graphical form for the, 'causes of stress', and, 'reduce stress', questions respectively.

Chart 3.20 Reported sources of stress at work

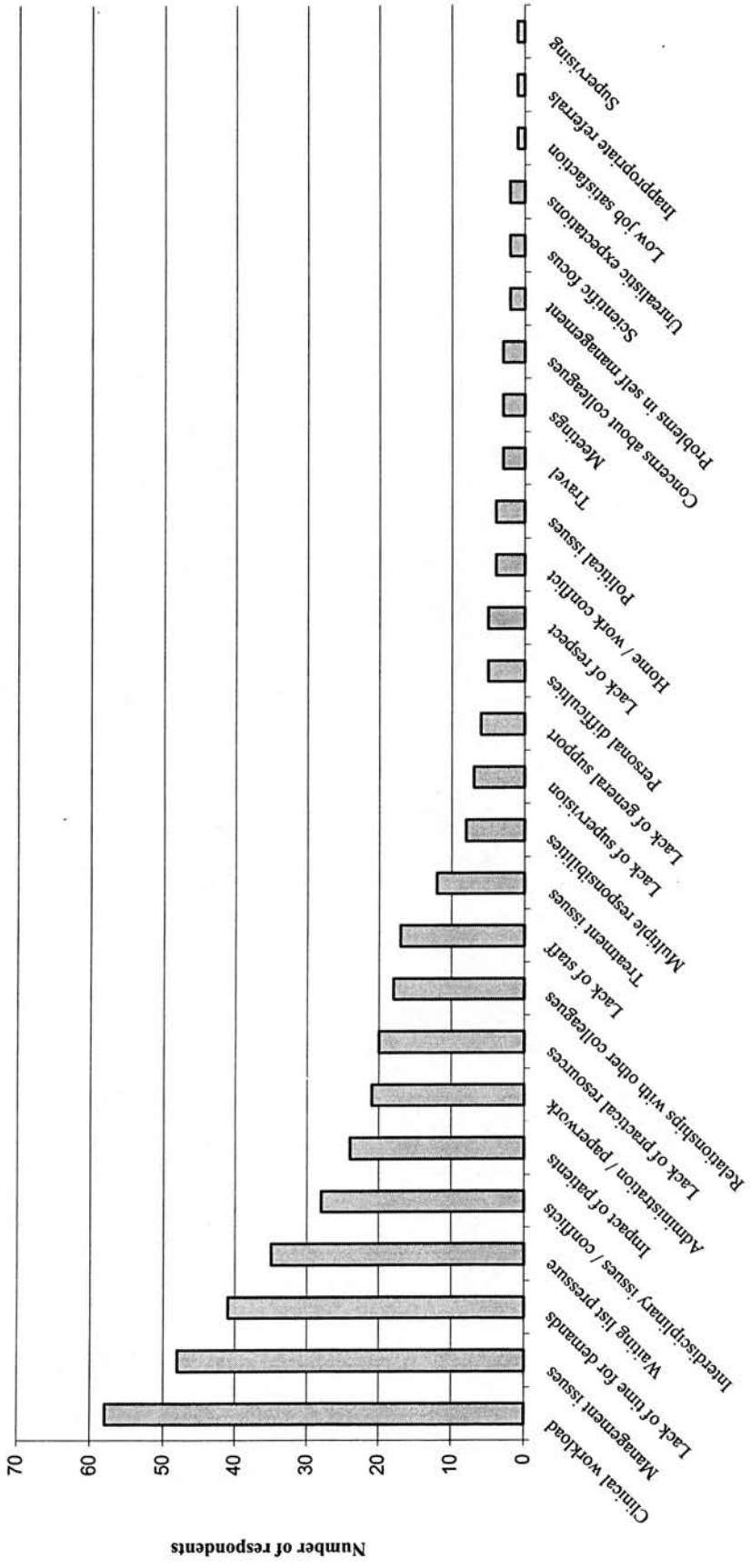
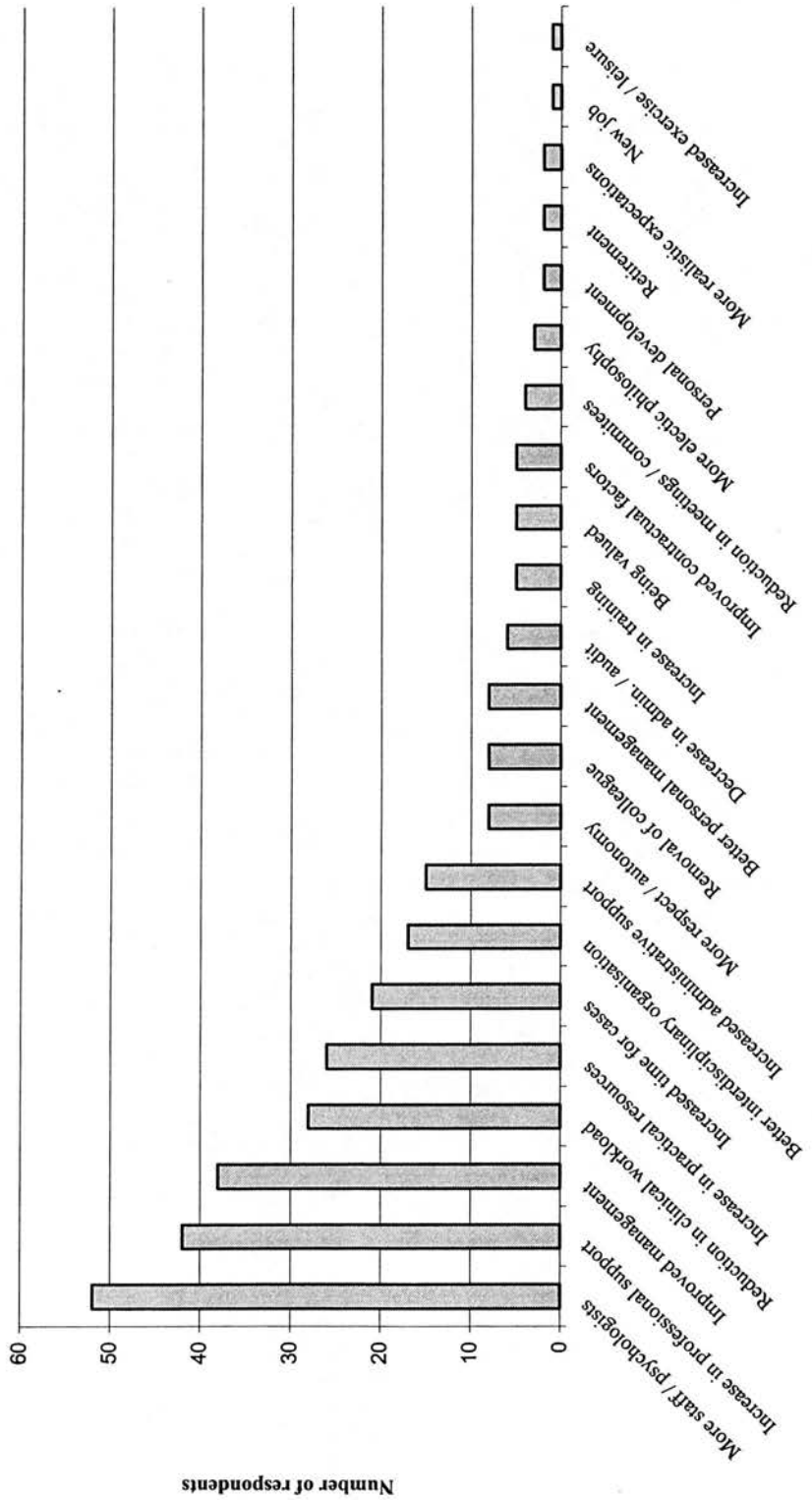


Chart 3.21 Reported factors that would make work less stressful



4. Discussion

4.1 Introduction

The main purpose of this project as outlined in the introduction was to investigate the extent of distress amongst clinical psychologists, the stressors they face and the support systems they have available to them in an effort to understand relationships between them. From this a number of more specific aims were developed which in turn gave rise to a number of experimental hypotheses. This discussion will relate the results of the study to its aims and hypotheses, and to the literature described in the introduction. Following this, limitations of the study will be discussed as well as avenues for possible future research.

4.2 Aims and Hypotheses

4.2.1 Professional and Personal Demographics

The first aim of the study was to investigate the professional and personal demographics of a population of clinical psychologists, and how these variables relate to well-being in that population. Section 3.2 summarises the professional and personal demographic data of the sample and provides a number of interesting findings. The first of these is the distribution of hours worked per week for the sample which shows that, although the mean hours worked per week was 35.3 hours, 35.6% of the sample worked over the normal full time hours of 37.5 hours per week, with a maximum reported hours per week of 60. These findings suggest that a significant number of psychologists work over a full time week and are likely to be working over the number of hours that they are paid for. The results did not indicate a wide range of factors that might influence the working of long hours, but a comparison between males and females suggested that on average male

psychologists work longer hours than their female counterparts. Male psychologists also had a higher average age, and years since qualification than the female psychologists, and as such the finding of higher average hours worked per week for males by be a product of age and seniority within the profession.

Secondly, the results showed that the sample were comparable with a recent survey of psychological services in Scotland (SCPMDE, 1999) in terms of area of work specialism. This finding that suggests that of the factors that might have influenced response to the study, area of work was not important. It also suggests that the sample group was representative of the Scottish clinical psychology population on this factor.

A third interesting finding from the study was the distribution of endorsed theoretical orientations in the sample. The findings show that 80.6% of the sample endorsed a cognitive behavioural theoretical orientation, with the second most frequently endorsed being 'other' at 7.2%, followed by neuropsychology at 5.6%. Little comparable data exists on the theoretical orientations of clinical psychologists in the United Kingdom. Zook and Walton (1989) carried out a study investigating theoretical orientations of clinical psychologists in America, and found that of 171 clinical psychologists surveyed, 34.5% endorsed a cognitive behavioural orientation, 34.5% a psychodynamic orientation, 18.7% a humanistic orientation, and 5.8% a systems orientation, results that are markedly different from the present study. Zook and Walton (1989) also examined the results using age as a between subjects variable, and found that the younger cohort endorsed cognitive behavioural orientations more than their older colleagues, and suggested that there was a shift in the profession away from psychodynamic and humanistic approaches towards more

cognitive behavioural orientations. While not directly comparable with an American psychologist population, the present results do suggest that cognitive behavioural thinking is, or has become the major theoretical orientation in Scottish clinical psychology.

This first aim also generated three hypotheses (Hypotheses 1, 2, and 5) predicting associations between demographics and well being. The results did not support the first two hypotheses, but instead showed no significant differences between male and female psychologists, or between single and attached psychologists on measures of well being, and experienced stressors. Furthermore, no significant correlations were found between age, work hours per week, and years since qualification, and measures of well being and work stressors, and thus hypothesis five was also not supported. In short, of the measured personal and professional demographics, none were associated with poorer well being, or with more experiencing of stressors. This finding is in contrast to previous studies (e.g. Cushway and Tyler, 1994, 1996; Farber, 1990; Thoreson *et al.*, 1989) that have suggested that being female, young, and single are risk factors for experiencing distress as a psychologists. Whilst it is not clear from the present data as to why previous findings in this area were not replicated, it does suggest that the finding is not a robust one and may vary from region to region, or indeed across time.

4.2.2 Specific Professional Supports

The second aim of the study concerned specific professional supports and their relationships with experienced stressors and well being. Prevalence figures for specific supports showed that less than 50.6% of the sample received no clinical supervision in their work, and that 81.8% received less than one hour per week of

supervision. Such a finding is worrying given the potential importance of supervision in the maintenance of clinical skills and continuing personal and professional development (Miller, 1990; Milne, 1998). It also in some contravention of the Division of Clinical Psychology's guidelines for professional practice (BPS, 1995a) which state that clinical supervision should be organised for *all* levels and grades of clinical psychologists as a way of maintaining and developing quality and range of skills.

The prevalence of continuing professional development (CPD) was somewhat better with 74.3% of the sample reporting having at least one hour per week of CPD. However, 12.2% of the sample reported receiving no CPD at all. Again this is in contravention to the professional guidelines laid down by the Division of Clinical Psychology which state that in order to maintain high standards of practice all clinical psychologists should participate in CPD regardless of status or level of experience.

Current use of personal therapy was low in the sample with only 6.1% of the sample reporting being in personal therapy at the time of the survey. This is much lower than the 30% reported by Darongkamas *et al.* (1994) in a study examining the use of personal therapy by clinical psychologists.

This second aim generated two hypotheses (Hypotheses 3 and 5) predicting associations between professional supports and experienced stressors and well being. The results showed that there was no significant differences between psychologists who were being supervised and those that were not on measures of work stressors and well being, and hypothesis 3 was not supported. No significant correlations were

found between hours of supervision and CPD per month, and experienced work stressors and well being, and therefore hypothesis 5 was not supported.

Such findings suggest that although supervision and CPD are, at least in theory, important for the maintenance and development of clinical skills and expertise, their presence or absence may not have a large impact upon the amount of stressors experienced or the well being of clinical psychologists.

The amount of provided supervision was also measured in the study and the results show that for this variable there was a positive association between the amount of hours of supervision provided, and experience of work stressors, suggesting that the provision of supervision by clinical psychologists may lead, either through direct or indirect means, to experiencing a greater number of stressors at work. Possible reasons for this could be the extra workload, responsibility, and confrontation with others' anxiety, providing supervision is likely to involve.

4.2.3 Professional Impairment

A third aim of the study was to investigate prevalence of professional impairment and its relationship with experienced work stressors and well being. The finding that 20% of the sample felt that their work was moderately or more severely impaired by the amount of stress they experience is a somewhat worrying finding, and does suggest that there may be a significant population of psychologists whose professional work is being compromised by the level of stress they are experiencing.

Hypothesis 4 was generated from this aim predicting associations between impairment and measures of experienced work stressors and well being. The results showed that there was a significant positive correlation between reported impairment and experienced work stressors, and scores on the GHQ. While the correlations are

not proof of cause they do suggest that level of professional impairment is associated with the amount of stressors experienced at work, as well as to the well being of the individual. If the link is to be thought of as a causatory one, as suggested by Sherman (1996) and Sherman and Thelen (1998), then the finding provides argument for the importance of minimising stressors at work as much as possible, and ensuring that their are systems that will recognise and address the personal distress of psychologists as quickly and effectively as possible.

4.2.4 Stressors and Well Being

The fourth aim of the study was to examine the prevalence of, and relationships between, work and non-work stressors and well being, an aim that generated two hypotheses (Hypotheses 6 and 7) predicting that levels of experienced work and non-work stressors would be positively associated with scores on the GHQ.

Results from the MHPSS scale indicated that the scores reported on the scale were comparable, if somewhat lower than those reported in an English cohort (Cushway *et al.*, 1996), and that highest scores were reported for the workload, and organisational structures subscales.

For work stressors the results showed significant positive correlations between total experienced work stressors (MHPSS total) and all subscales of the GHQ. Total work stressor scores showed the highest correlation with the anxiety, somatic, and depression subscales of the GHQ, with a smaller correlation being observed with the social dysfunction scale. This finding might be suggestive of experience of work stressors having specific health impacts upon an individual in terms of anxiety, depression, and somatisation, with a lesser effect on aspects of social dysfunction.

When the work stressor scores were broken down in to their individual subscales, they all showed significant correlations with overall GHQ scores. The strongest correlations here were between the workload, organisational structure, and home-work conflict subscales, and the GHQ, a finding that may be suggestive of particular areas of work stress having differential effects upon an individuals well being.

As well as significant subscale correlations, a significant correlation was observed between total experienced work stressors, and total GHQ scores, indicating a positive relationship between the experiencing of work stressors, and poorer health.

For non-work stressors as measured by the LES, significant correlations were found between total LES scores and all GHQ total and subscale scores, apart from the social dysfunction, with the strongest correlations being observed between LES scores and the anxiety and depression GHQ subscales. This is a similar finding to the one just described between work stressor scores and GHQ scores, where the experiencing of stressors is correlated most strongly with anxiety and depression scores, and to a lesser degree with social dysfunction. Assuming at least some stressor / well being causality, these results together are suggestive that the experiencing of stressors, work or otherwise, has specific health consequences, with anxiety and depression being the two most prominent outcomes. This lends support to a simple victimisation model of the stressor / well being relationship, and is in line with previous findings (e.g. Friedman *et al.*, 1992; Monroe *et al.,* 2001; Kessler, 1997; Paykel, 2001), but as discussed in the introduction it sheds little light on the mechanisms underlying the relationship.

4.2.5 Support and Well Being

The fifth aim of the study was to examine the prevalence and satisfaction with support systems and how measures of this related to well being.

An examination of the data from the support measures indicated that the results obtained in this study were comparable in magnitude and form to previously reported data. No comparable data was available for the professional support measure, but the pattern of results on this scale were similar to those on the social support scale.

Hypothesis 8 was generated from this aim, predicting that scores for perceived practical and emotional support, and total network size, would be negatively correlated with GHQ scores, while discrepancies between actual and ideal practical and emotional support would be positively correlated with GHQ scores.

For measures of social support, no significant correlation was found between total network size and GHQ score, while significant correlations were observed between measures of perceived practical support, emotional support discrepancy, practical support discrepancy, and GHQ total, all in the predicted direction. Perceived emotional support was not correlated with GHQ scores. A similar pattern was observed in the discrepancy correlations, with the largest correlation being observed between discrepancies in practical support and GHQ total, and the emotional support discrepancy being correlated to a lesser degree. Put together these results, suggest that in terms of social support, the perception of actual practical support, and the relative satisfaction with practical support may be more important to well being than the equivalents in emotional support.

For measures of professional support, no significant correlation was observed between total network size and well being. Significant correlations were observed

between perceived practical support, and discrepancy in practical support on the one hand, and GHQ scores on the other. In a similar finding to social support, no significant correlations were found between measures of emotional support and GHQ scores. The pattern observed in the associations between professional support and well being is similar to that seen in social support, with elements of practical support being related to well being, while emotional support measures show no such relationship.

Overall these particular results seem to suggest a relatively important place for the provision of satisfactory practical support in the experience of well being, both in terms of social and professional support systems, with the emotional components of support being relatively less important. Furthermore they suggest that the size of a support network exerts relatively little influence on well being.

4.2.6 Support and Stressors

The sixth aim of the study was to investigate the relationship between the prevalence and satisfaction with supports, and the experiencing of work and non-work stressors. Hypothesis 9 was generated from this aim, predicting correlations between measures of support and measures of stressors, as well as predicting that social and professional supports would be more strongly associated with non-work (LES total) and work stressors (MHPSS total) respectively.

For social supports no significant correlations were observed between total network size and the experience of stressors. Significant correlations in the predicted directions were observed between scores of perceived practical support, and discrepancy in that support, and work and non-work stressor totals. A significant correlation was found between discrepancy in emotional support and non-work

stressors, but not with work stressors, and no significant correlations were found between perceived emotional support and either of the stressor scores.

The magnitude of the correlations suggested that there was a greater association between measures of social support and the experience of work stressors, than with the experience of life stressors. This finding goes somewhat against the description of an exact 'matching hypothesis' as suggested by Cohen and Wills (1985), Frese (1999), and Horowitz *et al.,* (2001), and suggests that social support may be important both in limiting the experience of non-work, as well as work stressors.

For professional support, significant correlations were observed between total network size and scores on the work and non-work stressor scales. Interestingly the correlations seen were in the opposite direction to that predicted in the hypothesis, with greater network sizes being associated with higher stressor scores.

Significant correlations were found between measures of perceived practical support, discrepancy in practical support, and discrepancy in emotional support on the one hand, and work stressor scores on the other, but again no correlation was observed between perceived emotional support and stressor scores. No significant correlations were observed between professional support measures and non-work stressor scores.

These findings, in a similar vein to those described in the previous section, suggest a particular importance for the availability and satisfaction with practical support in the experiencing of stressors by an individual. They show an association between availability and satisfaction with practical support, and lower levels of both work and non-work stressors. The results also show that social support is associated with reduced levels of both work and non-work stressors, while professional support is only associated with reduced levels of work stressors. This suggests that the

matching hypothesis is more accurate for professional support than it is for social support, and that while professional support systems exert specific effects on work stressors and have little impact upon non-work stressors in line with a matching hypothesis, social support may operate in a more general nature and have an impact upon the experiencing of both non-work and work stressors.

The finding that total professional network size was positively correlated with both work and non-work stressor scores is an interesting finding, and although it is difficult to be sure as to the mechanism underlying the association it does suggest that mere quantity of professional supports does not reduced the experiencing of stressors, and may in fact increase it. One possible reason for this could be the increased opportunity for potential stressors such as interpersonal conflicts, the provision of support, and confrontation with potentially different ways of thinking or working, that being involved in a an extended professional network may bring.

4.2.7 Ways of Coping and Well Being

The seventh aim was concerned with the relationship between ways of coping and well being. This led to hypothesis 10 which predicted that emotion focused ways of coping would be associated with low levels of well being, while problem focused coping would be related to higher levels of well being.

The results showed that problem focused methods of coping were used more than emotion focused methods by the sample, and that a significant association was observed between emotion focused coping and well being in the predicted direction. No significant associations were observed between problem focused ways of coping and well being. An examination of the associations between emotion focused coping and well being showed that the association held for the GHQ total score, the GHQ

depression subscale, and the GHQ anxiety subscale, but that it did not hold for the GHQ somatic or social dysfunction scales.

While not supporting the hypothesis that problem focused ways of coping are associated with higher levels of well being, these results do show that in this sample the use of emotion focused ways of coping is associated with lower levels of well being, and in particular with the experiencing of anxiety and depression. This is a similar finding to that described by Cushway and Tyler (1994) who found that, in a sample of psychologists, coping mechanisms which avoided doing anything about the stressor were related to poorer outcome. Together these results suggest that the use of coping strategies directed at changing the stressor are more adaptive in terms of well being, than strategies which either ignore or avoid the stressor.

4.2.8 Support as a Moderator in the Stressor / Well Being Relationship

As discussed in the introduction, support has been frequently described as a moderator in the relationship between stressors and well being (e.g. Cohen and Wills, 1985; Frese, 1999; Thoits, 1986), in models that suppose the use of supports are a resource that can be used productively in the face of a stressor. The eighth aim of the study was to examine this relationship and to investigate to what extent perceived support and satisfaction with that support affected the stressor / well being association. Hypothesis 11 related to this aim and predicted that measures of support would moderate the stressor / well being relationship, and that professional supports would have a greater impact upon work stressor / well being relationships, and social supports on non-work stressor / well being relationships.

The use of a median split ANOVA with GHQ scores as the dependent variable was used with the prediction that for both social and professional support there would be

significant interactions between levels of support, levels of stress, and well being. Table 4.1 summarises the predicted levels of relative well being of the four groups.

Table 4.1 Predicted levels of relative well being for buffering hypothesis

	High levels of experienced stressors	Low levels of experienced stressors
High levels of perceived support / Low support discrepancy	−	+ +
Low levels of perceived support / High support discrepancy	− −	+

None of the analyses showed any significant interactions between levels of support and stressors with well being as the dependent variable. It is accepted that this was only a crude measure of any buffering hypothesis but the results do not support a buffering hypothesis for either social support or professional support upon their respective stressor / well being associations. This finding suggests that while the experiencing of stressors, and elements of support have direct relationships with well being, these relationship operate independently of one another.

4.2.9 Regression Analyses

Due to the fact that little research has been carried out examining the factors that contribute to well being among clinical psychologists, a regression analysis was carried out in which variables assumed to have potential contributory value were entered. The first analysis which entered all the potentially relevant variables in to a regression equation with GHQ scores as the dependent variable indicated that the experience of work stressors (MHPSS total), experience of non-work stressors (LES total), and discrepancy in practical support from social sources, were the only significant contributors to the GHQ score. A stepwise regression confirmed this

finding and suggested that work stressor totals were the largest predictor of GHQ totals, with non-work stressor, and practical social support discrepancy contributing to a lesser degree.

The finding that the experiencing of stressors, both of a work and non-work related variety, predict scores on a measure of well being is an intuitive finding that is very much in line with the models outlined in the introduction. The finding that discrepancy scores on practical social support measures is slightly less intuitive and is suggestive of the importance of satisfaction with perceived practical support in the prediction of well being. The three predictive measures are all correlated with one another, and it is impossible to accurately model how the three variables operate in their relationship with well being in the present study. Despite this, the finding does suggest that perceived satisfaction with practical support does play an important role in the stress process.

The finding that work stressor scores were the most significant predictor of GHQ scores highlights the potential importance of work stress in the well being of clinical psychologists. Given this finding a second set of regression analyses were carried out using work stressor scores (MHPSS total) as the dependent variable.

A regression using the enter method showed that the use of emotion focused coping strategies, hours worked per week, and total professional support network size were the only three significant predictors of MHPSS scores. The stepwise regression confirmed these three variables as significant predictors and added discrepancy in professional practical support, and perceived social practical support as further predictors. In a model including all five predictor variables the use of emotion focused coping accounted for the greatest degree of MHPSS variance, followed by

discrepancy in professional practical support, professional support network size, actual practical social support, and finally hours worked per week. In terms of work related variables, the results of this second regression analysis point to an important role for satisfaction with practical professional support, hours worked per week and the size of professional network available to a psychologist. The positive relationship between hours worked per week and experience of work stressors is an interesting finding that may be explained in both directions of the relationship, with an increased amount of work stressors meaning more time has to be spent at work, or more time being spent at work leading to the experience of more stressors.

The other two significant work variables again point to the relative importance of practical support (or satisfaction with practical support) in the workplace, but also suggest that mere quantity of available supports is not sufficient to reduce the experiencing of stressors, and in fact may cause an increase in it. In short, it is the satisfaction with professional support that is associated with lower levels of experienced stressors, rather than the quantity.

The regression analysis also points to the use of emotion focused ways of coping as a strong predictor of experiencing work stressors. One possible explanation for this is that because emotion focused coping does not bring about any direct effect upon the stressor itself, e.g. through modifying, tackling or removing it (Folkman and Lazarus, 1980; Lazarus, 1993), when used as a primary way of coping it is likely to mean that any stressors present in an individual's environment remain present, unchanged, and therefore still potentially stressful for longer periods of time.

Perceived levels of practical social support were also significant in predicting MHPSS scores, again pointing to the relative importance of practical support, as well

as suggesting that elements of social support can have an impact upon the experiencing of work related stressors.

4.2.10 Qualitative Stress Data

The tenth aim of the study was to investigate within an unstructured response frame what psychologists reported as the most stressful aspects of their work, and their ideas about how their work could be made less stressful. The results showed that issues relating to the size of the psychologist's clinical workload was the most frequently cited cause of stress (32.2%). This finding reflects the results from the MHPSS scale of this study where the workload subscale had the largest mean scores, and mirrors Cushway and Tyler's (1994) study where, 'too much work', was the most frequently endorsed cause of stress in psychologists using a structured questionnaire. The next two highest reported work stressors in this study were also the same as Cushway and Tyler's (1994) sample group, being, management issues, (26.7%), and lack of time for demands (22.8%). The next six reasons given in descending order of frequency were; waiting list pressure (19.4%), interdisciplinary issues / conflicts (15.6%), impact of patients (13.3%), administration and paperwork (11.7%), lack of practical resources (11.1%) and relationships with other colleagues (10%). These findings are again markedly similar to Cushway and Tyler's (1994) group, and suggest that workload issues, issues related to management and organisation, interdisciplinary issues, lack of resources, and the impact of patients are the most prevalent stressors in the psychologist's workplace. One interesting finding is that 10% of the sample reported relationships with colleagues as a stressor. This may at least partly explain the finding that larger professional support networks were associated with poorer well being in this study.

The sample's ideas about what would reduce stress at work were largely in line with their responses to the causes of stress question, and similar to those reported by the Cushway and Tyler (1994) sample, with more staff (28.9%), improved management (21.1%), reduction in clinical workload (15.6%), increase in practical resources (14.4%), and increased time for cases (11.7%), all offering direct responses to the most frequently cited causes of stress. Interestingly, however, the second most frequently cited idea relating to the reduction of stress was increase in professional support (23.3%), and yet the lack of support systems was not frequently cited as a stressor by psychologists (Lack of supervision, 3.9%; lack of general support, 3.3%). This finding suggests that while individuals may not view the lack of support systems as a particularly major cause of stress in itself, the perception that support is available to them is viewed as relatively important as a way of reducing the amount of stress they experience. Such an idea is in line with the models of the stress process such as those proposed by Thoits (1986), and Lazarus and Folkman (1984), which describe support as a resource that can be used in the face of a stressor, rather than it being a stressor itself.

4.2.11 General Levels of Distress in Psychologists

The eleventh aim of the study was to make an assessment of the general levels of distress in a population of clinical psychologists. The results showed that of the responding sample group 53.3% felt moderately or very stressed by their work, a figure lower than Sampson's (1991) finding of 68% in a 1989 survey of Scottish psychologists.

The results also allowed for an estimation of just significant clinical caseness to be obtained and compared with previous studies. The finding that 37.8% of the sample

scored at above cut off for caseness is comparable with previous studies, and somewhat higher than the 33% reported by Sampson (1991). Cushway and Tyler (1996) also reported rise in caseness of comparable samples over a five year time period, and suggested that the rise may have been due to changed conditions in the NHS causing increasing distress amongst its staff. Whatever the factors contributing to any rise in distress levels amongst Scottish clinical psychologists, a caseness level of 37.8% does appear to be alarmingly high considering the association between distress and professional impairment, and the personal costs to the individuals experiencing such levels of distress. This study did not specifically investigate treatment for distress. It did, however, measure frequency of involvement in personal therapy: one source of help which one might think was particularly obvious to clinical psychologists. As previously described the use of personal therapy was low in the sample group (N=11, 6.1%). A post hoc analysis indicated that in the sub-group who scored above cut-off for caseness the use of personal therapy was higher (N=8, 11.8%), than that of the non-case subgroup (N=3, 2.7%). There was no significant difference between the case and non-case subgroups on mean number of hours of personal therapy ($t = 1.563$, $df = 178$, $p = 0.120$ ns), however the small numbers involved make it difficult to draw implications from this. These results show that although a larger proportion of the case group used personal therapy, its use was still low. This implies either that the distressed group were engaging in a form of treatment not covered in the study, or were not receiving any treatment at all. Either way the finding supports the argument of Nichols (1988), that psychologists in distress are not always practising what they preach.

4.2.12 Reliability of Measures

The study provided an opportunity to measure the internal reliability of two of the measures used in it. The first of these was the WCQ, with responses being classed as either emotion focused or problem focused ways of coping. No previous reliability data was found for this scale using these dimensions. Data from the present study showed that the two dimensions of emotion focused and problem focused had Cronbachs alpha's of 0.73 and 0.77 respectively. These levels indicate an acceptable level of internal reliability for the number of items within each dimension (Carmines and Zeller, 1979).

The second measure for which internal reliability scores were calculated was the MHPSS. The rationale for this was that the measure is a relatively new one with little reliability data available, and the present study allowed for reliability to be measured using data from a population size larger than any previously reported. Acceptable reliability levels were obtained for all but three of the MHPSS subscales, and an acceptable level was found for the MHPSS total score (Chronbachs alpha = 0.89). The three subscales that achieved low reliability scores were client-related difficulties, lack of resources, and home-work conflict. This replicates data presented in a previous reliability study (Mehrotra *et al.,* 2000) and suggests some further work may be required in factor analysing the MHPSS to identify subscales with acceptable levels of internal reliability.

4.3 Summary and Implications

4.3.1 How Stressed are Clinical Psychologists ?

The present study indicates a high prevalence rate of stress amongst clinical psychologists as measured by a simple likert scale, and by a more comprehensive general health questionnaire. Data from this study also suggest that experienced distress is associated with professional impairment, and that support systems such as supervision and personal therapy are not routinely available or used by practising psychologists. These findings argue for distress recognition and alleviation systems to be developed and incorporated into departments of clinical psychology as a matter of routine, if both psychologist and their patients are to be protected from the negative impacts of stress.

4.3.2 Which Psychologists are Most Distressed ?

Unlike previous studies, the present study did not identify any particular psychologists who are most vulnerable to distress based upon personal demographics. Age, sex, and relationship status have all previously been shown to be associated with higher levels of distress (Coster and Schwebel, 1997; Cushway and Tyler, 1996; Farber, 1990), but such findings are not replicated in this study. In terms of professional demographics, none of the variables of hours of supervision, hours of continued professional development, hours of personal therapy, hours of provided supervision, hours worked per week, or years since qualification showed any association with scores for well being. The implication of this finding is that the 'at risk' psychologist is not easily identified from demographic data alone, and that all psychologists are potentially at some risk of experiencing distress.

4.3.3 What Factors are Associated with the Experience of Distress ?

The experiencing of higher levels of stressors, both of a work and non-work variety was associated with poorer well being. In terms of work stressors, the results suggest that stressors relating to workload, organisational and management issues, and home-work conflict are most strongly associated with poorer well being. Psychologists also reported these, along with patient impact, lack of resources and relationships with other colleagues as the most prevalent sources of stress. Psychologists also reported the alleviation of these factors as ideas for reducing stress, as well as suggesting an increase in levels of professional support.

Results from the support measures showed that the perception and satisfaction with both socially and professionally provided practical support was associated with lower psychopathology scores. These findings suggest that it is the practical aspects of support systems that have the biggest impact upon well being. Higher levels of the practical elements of support were also associated with the experiencing of fewer stressors. Perception and satisfaction with practical social support was associated with lower experienced work and non-work stressors, while the same measures for professional support were only associated with lower levels of work related stressors. The finding that elements of practical support are more important predictors than elements of emotional support in the stress transaction is an interesting finding for which various reasons could be speculated. One possible reason is that within a working environment the actual major sources of stress are created by a lack of, or limitations in the amount, quality, or availability of practical resources. If this were the case then the perception or actual provision of practical supports may be of more use than emotional supports. For example the provision of a dedicated computer and

desk may prove more potent in reducing stress than a kind or understanding word from a colleague. The implication here is that departments should focus on assessing what the practical needs of it's workforce are when considering how best to manage stress in the workplace.

One network size effect was observed, that of larger professional network sizes being associated with higher levels of experienced work stressors. These results suggest that the practical elements of support are useful in reducing the amount of stressors experienced, and that while social support can be useful across the board, professional support works primarily on work related stressors. The network size finding also points to the importance of the perception and satisfaction with support, rather than the actual presence of support as important in well being, and that larger professional network sizes may do more harm than good.

The findings from the support measures suggest that independent of the lack of association between formally measured professional support e.g. supervision, continued professional development, and well being, the perception and satisfaction with aspects of both social and professional support can influence both the number of stressors experienced, and well being itself. Presumably this support acts directly upon the individual given the fact that the data from this study showed no evidence of the buffering effect described by Cohen and Wills (1985). The implications for clinical psychology services are that the provision of support can be associated with reduced stressors and improved well being for staff, but that it may be important to focus efforts of support predominantly on the type of support provided rather than its mere presence or quantity, with potentially a leaning towards the provision of practically orientated support.

Finally the use of emotion focused coping was associated with higher psychopathology scores, and was the single largest predictor of the variance in work stressor scores. While not providing an endorsement of problem focused coping strategies, this finding does suggest that the use of a coping strategy which does not have a direct effect upon the stressor is associated with the experience of more stressors and, presumably as a consequence, poorer well being.

4.4 Limitations of the Study

One limitation of the present study is the response rate. Even though the sample size was large, it only represented 56.3% of the target population and as such generalisations to the population as a whole should be made with caution. There was no way of verifying how representative the responding sample was other than by comparison with the SCPMDE (1999) survey of specialism breakdown. Although this comparison was favourable, however, it does remain possible that other biases may have been in operation in the present study. One could have been from an over-inclusion of distressed psychologists in the sample who responded due to the survey 'striking a chord' with them. Another could have been a possible under-inclusion of distressed psychologists, due to an unwillingness to report the levels of distress they were experiencing.

A further limitation of the study was the reliance upon self report measures for all measured variables. No independent verification of the extent of distress, impairment, stressors, or support was available. All the data therefore may have been influenced by subjective biases of each responder. Similarly, each of the measures relied to a certain degree upon memory, and taking time to fill in the questionnaires. Factors such as these could potentially have introduced error into the recorded data,

with item responses reflecting other factors such as questionnaire weariness, or general mood, as well as the target construct.

As with all correlational studies, the present study can not make any definitive statements about causality but can only point to certain variables associated with the experiencing of stressors and well being in, as yet, undetermined ways. This limitation means that no firm conclusions can be reached as to the factors that *cause* well being or impairment amongst psychologists, but can only offer a snapshot description of factors that are associated with one another. This snapshot nature of the study is a further limitation as it prevents any kind of dynamic or developmental picture of distress to be established.

Another limitation of the study relates to the variables that were not measured in the study but may theoretically play an important part in the development of distress. These variables may indeed underlie some of the variables that were measured in the study. For example: aspects of an individual's personality, or their psychosocial history and development may play an important part both in the experience of distress, as well as the subjective reporting of support systems. This may mean that associations between variables observed in the study may have been, at least in part, due to the extent to which they were both representative of a shared underlying construct such as personality type.

4.5 Future Research

Future research might include a replication using a longitudinal design that would better be able to show directions of causality in the observed associations. Similarly, a smaller focus group design may shed light on some of the reasons behind results found in this study, such as the low levels of received supervision, and low use of

personal therapy. Future research could also place an emphasis on investigating what support systems not covered in this study, if any, are available for use by psychologists in Scotland, and to what extent they are used and valued.

Future work might also investigate variables not measured within this study, but undoubtedly of importance in the experience of distress amongst psychologists. At a general level, these might include measures of personality, and psychosocial history and development, while at a more specific level they might include further aspects of the stress process such as appraisal style.

Given the importance of any link between psychologist distress and a negative impact upon patient care, future work could also focus on investigating this link more thoroughly, using both subjective and objective measures of both distress and impairment.

5. Conclusions

Given the limitations of this study, perhaps the most robust conclusions that can be drawn relate to the raw data collected. From this data it can be concluded that the presence of professional support systems, such as clinical supervision, is low for clinical psychologists working in Scotland, and as such is in contradiction to the professional guidelines laid down by the profession. Furthermore there is a high prevalence of distress amongst clinical psychologists, as well as a high frequency of hours over a normal full time week being worked. While the data does not show any definite causatory factors in the production of distress, it does point to a number of variables such as workload, lack of resources, perceived poor management, and ways of coping as having some associations.

Given these conclusions it might be argued that systems for the recognition, management, and treatment of stress be incorporated at all levels of the profession, including training, in an effort both to prepare psychologists for the likelihood of encountering work related stress, and to provide them with services and opportunities to deal with it should it become something they experience. However, the present study does not provide any firm conclusions as to what would alleviate any experienced distress, but does suggest that the provision of support, and perhaps practical support in particular, as well as improved management and more psychologists to carry out the work, may potentially play important roles. It is likely however, as predicted by the models outlined in the introduction, that the production, as well as the alleviation, of distress amongst clinical psychologists is a multi-factorial, multiply interacting system, of which this project has only been able to make preliminary comments about.

References

Ackerley, G.D., Burnell, J., Holder, D.C., and Kurdek, L.A., (1988). Burnout Among Licensed Psychologists. *Professional Psychology: Research and Practice,* **19(6),** p 624-631.

Aldwin, C.A., and Revenson, T.A., (1987). Does Coping Help? A Reexamination of the Relation Between Coping and Mental Health. *Journal of Personality and Social Psychology,* **53,** p 337-348.

Aldwin, C.M., Sutton, K.J., and Lachman, M., (1996). The Development of Coping Resources in Adulthood. *Journal of Personality,* **64(4),** p 837-871.

Arnold, M.B., (1945). Physiological Differentiation of Emotional States. *Psychological Review,* **52,** p 35-48.

Arnott, S., Dorkins, E., and Aylard, P., (1996)." The Sorcerer and The Apprentice" A Study of Clinical Supervision of Psychotherapy and Counselling Occurring in a District Wide General Adult Psychiatric Service. *Psychiatric Bulletin,* **20,** p 609-611.

Ausubel, D.P., (1996). *Ego Development and Psychopathology.* New Brunswick, NJ: Transaction Publishers.

Barrera, M., and Garrison-Jones, C., (1992). Family and Peer Social Support as Specific Correlates of Adolescent Depressive Symptoms. *Journal of Abnormal Child Psychology,* **20,** p 1-16.

Beck, A.T., (1976). *Cognitive Therapy and the Emotional Disorders.* New York: International Universities Press.

Beehr, T., (1995). *Psychological Stress in the Workplace.* London: Routledge.

Bergin, S.L., and Garfield, S.L. (Eds.), (1994). *Handbook of Psychotherapy and Behavior Change,* 4th Ed., New York: Wiley.

Beutler, L.E., Machado, P.P., and Allstetter Neufeldt, S., (1994). Evaluating the Ingredients of Therapeutic Efficacy: Therapist Variables. In, Bergin, S.L., and Garfield, S.L. (Eds.), *Handbook of Psychotherapy and Behavior Change,* 4th Ed., New York: Wiley.

Billings, A.G., and Moos, R.H., (1982). Work Stress and the Stress Buffering Roles of Work and Family Resources. *Journal of Occupational Behaviour,* **3,** p 215-232.

Billings, A.G., and Moos, R.H., (1984). Coping, Stress, and Social Resources Among Adults With Unipolar Depression. *Journal of Personality and Social Psychology,* **46,** p 877-891.

Binder, J.L., (1993). Is It Time To Improve Psychotherapy Training. *Clinical Psychology Review,* **13,** p 301-318.

Bolger, N., (1990). Coping as a Personality Process: A Prospective Study. *Journal of Personality and Social Psychology,* **59,** p 525-537.

Bongar, B., and Beutler, L.E., (Eds.), (1995). *Comprehensive Textbook of Psychotherapy.* Oxford: Oxford University Press.

Bowden, G., (1994). Work Stress, Burnout and Coping: A Review and Empirical Study of Staff in Supported Housing. *Clinical Psychology and Psychotherapy,* **1(4),** p 219-232.

Bowlby, J., (1969). *Attachment.* London: Hogarth Press.

Brems, C., Johnson, M.E., and Galluci, P., (1996). Publication Productivity of Clinical and Counseling Psychologists. *Journal of Clinical Psychology,* **52(6),** p 723-725.

British Psychological Society, (1991). *Code of Conduct, Ethical Principles, and Guidelines.* Leicester: BPS.

British Psychological Society, (1995a). *Professional Practice Guidelines 1995 Division of Clinical Psychology.* Leicester: BPS.

British Psychological Society, (1995b). *Professional Psychology Handbook.* Leicester: BPS Books.

Brooks, J.M.B., (1999). Personality Style, Psychological Adaption and Expectations of Psychologists in Clinical Training. *Dissertation for D. Clin. Psychol.* South Thames (Salomons) Clinical Psychology Training Scheme.

Brown, G.W., Andrews, B., Bifulco, A., and Veiel, H., (1990). Self Esteem and Depression: Measurement Issues and Prediction of Onset. *Social Psychiatry and Psychiatric Epidemiology,* **25,** p 200-209.

Brown, G.W., and Harris, T.O., (1978). *Social Origins of Depression: A Study of Psychiatric Disorder in Women.* London: Tavistock Publications.

Brown, G.W., and Harris, T.O., (1989). *Life Events and Illness.* New York: Guilford Press.

Brugha, T.S., (1995). Social Support and Psychiatric Disorder: Overview of Evidence. In, Brugha, T.S. (Ed.), *Social Support and Psychiatric Disorder. Research Findings and Guidelines for Clinical Practice.* Cambridge: Cambridge University Press.

Brugha, T.S. (Ed.), (1995). *Social Support and Psychiatric Disorder. Research Findings and Guidelines for Clinical Practice.* Cambridge: Cambridge University Press.

Buckley, P., Karasu, T.B., and Charles, E., (1981). Psychotherapists View Their Personal Therapy. *Psychotherapy: Research and Practice,* **18,** p 299-305.

Burley, A.G.W., (1999). *A Preliminary Examination and Comparison of the Treatment Approaches of Clinical and Counselling Psychologists in a Primary Healthcare Setting.* Small Scale Research Project for D.Clin.Psych., East of Scotland Training Course in Clinical Psychology, University of Edinburgh.

Buunk, B.P., and Hoorens, V., (1992). Social Support and Stress: The Role of Social Comparison and Social Exchange Processes. *British Journal of Clinical Psychology,* **31,** p 445-457.

Caplan, G., (1974). *Support Systems and Community Mental Health.* New York: Behavioural Publications.

Carifio, M.S., and Hess, A.K., (1987). Who is the Ideal Supervisor? *Professional Psychology: Research and Practice,* **18,** p 244-250.

Carmines, E.G., and Zeller, R.A., (1979). *Reliability and Validity Assessment.* London: Sage Publications.

Carver, C.S., and Schier, M.F., (1994). Situational Coping and Coping Dispositions in a Stressful Transaction. *Journal of Personality and Social Psychology,* **66,** p 184-195.

Cassel, J., (1976). The Contribution of the Social Environment to Host Resistance. *American Journal of Epidemiology,* **104,** p 107-123.

Champion, L., (1990). The Relationship Between Social Vulnerability and the Occurrence of Severely Threatening Life Events. *Psychological Medicine,***20,** p 157-161.

Champion, L., (1995). A Developmental Perspective on Social Support Networks. In, Brugha, T.S. (Ed.), *Social Support and Psychiatric Disorder. Research Findings and Guidelines for Clinical Practice.* Cambridge: Cambridge University Press.

Champion, L., Goodall, G., and Rutter, M., (1995). Behaviour Problems in Childhood and Stressors in Early Adult Life 1: A 20 Year Follow Up of London School Children. *Psychological Medicine,* **25,** p 231-246.

Champion, L., and Power, M.J., (1995). Social and Cognitive Approaches to Depression: Towards a New Synthesis. *British Journal of Clinical Psychology,* **34,** p 485-503.

Chiesa, M., and Fonagy, P., (1999). From the Efficacy to the Effectiveness Model in Psychotherapy Research: The APP Multi-Centre Approach. *Psychoanalytic Psychotherapy,* **13(3),** p 259-272.

Cianfrini, C.L., (1997). A Comparison of University Academic and Psychological Counsellors: Burnout and its Relationship with Social Support, Coping, and Job Satisfaction. *Dissertation Abstracts International: Section A: Humanities and Social Sciences,* **57(9A),** 3824.

Clark, M.M., (1986). Personal Therapy: A Review of Empirical Research. *Professional Psychology: Research and Practice,* **17,** p 541-543.

Cleary, P.D., Goldberg, I.D., Kessler, L.G., and Nycz, G.R., (1982). Screening for Mental Disorder Among Primary Care Patients. *Archives of General Psychiatry,* **39,** p 837-840.

Cobb, S., (1976). Social Support as a Moderator of Life Stress. *Psychosomatic Medicine,* **38,** p 300-314.

Coe, C.L., (1993). Psychosocial Factors and Immunity in Non-Human Primates: A Review. *Psychosomatic Medicine,* **55,** p 298-308.

Cohen, F., (1987). Measurement of Coping. In, Kasl, S.V., and Cooper, C.L. (Eds.), *Stress and Health: Issues in Research Methodology.* New York: Wiley.

Cohen, S., and Wills, T.A., (1985). Stress, Social Support, and the Buffering Hypothesis. *Psychological Bulletin,* **98(2),** p 310-357.

Conner, M., (1999). Training and Supervision Make a Difference. In, Feltham, C. (Ed.), *Controversies in Psychotherapy and Counselling.* London: Sage Publications.

Costa, P., Somerfield, M., and McCrae, R., (1996). Personality and Coping: A Reconceptualisation. In, Zeidner, M., and Endler, N. (Eds.), *Handbook of Coping.* New York: Wiley.

Coster, J.S., and Schwebel, M., (1997). Well-Functioning in Professional Psychologists. *Professional Psychology: Research and Practice,* **28(1),** p 5-13.

Cox, T., (1990). The Recognition and Measurement of Stress: Conceptual and Methodological Issues. In, Corlett, N., and Wilson, J. (Eds.), *Evaluation of Human Work.* London: Taylor and Francis.

Cox, T., and Ferguson, E., (1991). Individual Differences, Stress, and Coping. In, Cooper, C.L., and Payne, R. (Eds.), *Personality and Stress: Individual Differences in the Stress Process.* Chichester: John Wiley.

Coyne, J.C., and Downey, G., (1991). Social Factors and Psychopathology: Stress, Social Support, and Coping Processes. *Annual Review of Psychology,* **42,** p 401-425.

Coyne, J.C., and Gottleib, B.H., (1996). The Mismeasurement of Coping by Checklist. *Journal of Personality,* **64(4),** p 959-991.

Coyne, J.C., and Racioppo, M.W., (2000). Never the Twain Shall Meet? Closing the Gap Between Coping Research and Clinical Intervention. *American Psychologist,* **55(6),** p 655-664.

Cramer, P., (2000). Defense Mechanisms in Psychology Today: Further Process for Adaption. *American Psychologist,* **55(6),** p 637-646.

Cushway, D., (1992). Stress in Clinical Psychology Trainees. *British Journal of Clinical Psychology,* **31**, p 169-179.

Cushway, D., and Tyler, P.A., (1994). Stress and Coping in Clinical Psychologists. *Stress Medicine,* **10,** p35-42.

Cushway, D., and Tyler, P.A., (1996). Stress in Clinical Psychologists. *International Journal of Social Psychiatry,* **42(4),** p 141-149.

Cushway, D., Tyler, P.A., and Nolan, P., (1996). Development of a Stress Scale for Mental Health Professionals. *British Journal of Clinical Psychology,* **35,** p 279-295.

Cushway, D., Watson, P., and Appleby, K., (1998). Therapy Network: A Therapy Service for West Midlands Clinical Psychology Staff. *Clinical Psychology Forum,* **115 (May),** p 17-20.

Dallal, C.E., (1986). PC-Size: A Program for Sample Size Determinations. *The American Statistician,* **40,** p 52.

Darongkamas, J., Burton, M.V., and Cushway, D., (1994). The Use of Personal Therapy by Clinical Psychologists Working in the United Kingdom. *Clinical Psychology and Psychotherapy,* **1(3),** p 165-173.

Decker, P.J., and Borgen, F.H., (1997). Dimensions of Work Appraisal: Stress, Strain, Coping, Job Satisfaction, and Negative Affectivity. *Journal of Counseling Psychology,* **40(4),** p 470-478.

De Ridder, D., (1997). What is Wrong With Coping Assessment? A Review of Conceptual and Methodological Issues. *Psychology and Health,* **12,** p 417-431.

DeRubeis, R.J., and Crits-Christoph, P., (1998). Empirically Supported Individual and Group Psychological Treatments for Adult Mental Disorders. *Journal of Consulting and Clinical Psychology,* **66(1),** p 37-52.

Dewe, P., Cox, T., and Ferguson, E., (1993). Individual Strategies for Coping with Stress at Work: A Review. *Work and Stress,* **7(1),** p 5-15.

Division of Clinical Psychology, (2001). *The Core Purpose and Philosophy of the Profession.* Leicester: BPS.

Dohrenwend, B.S., and Dohrenwend, B.P., (1981). Social and Cultural Influences on Psychopathology. *Annual Review of Psychology,* **25,** p 417-452.

Dohrenwend, B.P., and Shrout, P.E., (1985). "Hassles" in the Measurement of Life Stress Variables. *American Psychologist,* **40,** p 780-785.

Dolan, C.A., and White, J.W., (1988). Issues of Consistency and Effectiveness in Coping with Daily Stressors. *Journal of Research in Personality,* **22,** p 395-407.

Dormann, C., and Zapf, D., (1999). Social Support, Social Stressors at Work, and Depressive Symptoms: Testing for Main and Moderating Effects with Structural Equations in a Three-Wave Longitudinal Study. *Journal of Applied Psychology,* **84(6),** p 874-884.

Dunbar, M., (1995). The Well Being of Dementia Caregivers: A Series of Meta-Analyses with Empirical Confirmation. *Unpublished Ph.D. Thesis.* Edinburgh: Queen Margaret College.

Dunbar, M., Ford, G., and Hunt, K., (1998). Why is the Receipt of Social Support Associated with Increased Psychological Distress? An Examination of Three Hypotheses. *Psychology and Health,* **13,** p 527-544.

Edwards, J.R., (1988). The Determinants and Consequences of Coping with Stress. In, Cooper, C.L., and Payne, R. (Eds.), *Causes, Coping, and Consequences of Stress at Work.* Chichester: John Wiley.

Ekstein, R., and Wallerstein, R.S., (1972). *The Teaching and Learning of Psychotherapy* (2nd ed.). New York: International Universities Press.

Elliot, D.M., and Guy, J.D., (1993). Mental Health Professionasl versus Non-Mental-Health Professionals: Childhood Trauma and Adult Functioning. *Professional Psychology: Research and Practice,* **24,** p 83-90.

Ellis, M.V., Ladany, N., Krengel, M., and Schult, D., (1996). Clinical Supervision Research From 1981 to 1993: A Methodological Critique. *Journal of Counselling Psychology*, **43,** p 35-50.

Ellsworth, P.C., and Smith, C.A., (1988). From Appraisal to Emotion: Differences Among Unpleasant Feelings. *Motivation and Emotion,* **12,** p 271-302.

Evans, P., (1998). Stress and Coping. In, Pitts, M. and Phillips, K. (Eds.), *The Psychology of Health: An Introduction.* London: Routledge.

Eysenck, H.J., (1949). Training in Clinical Psychology: An English Point of View. *American Psychologist*, **4,** p 173-176.

Eysenck, H.J., (1952). The Effects of Psychotherapy: An Evaluation. *Journal of Consulting Psychology,* **16,** p 319-324.

Farber, B.A., (1990). Burnout in Psychotherapists: Incidences, Types and Trends. *Psychotherapy in Private Practice,* **8(1),** p 35-44.

Farber, B.A., and Heifitz, L.J., (1981). The Satisfactions and Stresses of Psychotherapeutic Work: A Factor Analytic Study. *Professional Psychology,* **12(5),** p 621-630.

Farber, B.A., and Heifitz, L.J., (1982). The Process and Dimensions of Burnout in Psychotherapists. *Professional Psychology,* **13,** p 293-301.

Feltham, C. (Ed.), (1999). *Controversies in Psychotherapy and Counselling.* London: Sage Publications.

Ferguson, G.A., (1976). *Statistical Analysis in Psychology and Education* (4th Ed.). Tokyo: McGraw-Hill.

Folkman, S.K., (1992). Making the Case for Coping. In, Carpenter, B.N. (Ed.), *Personal Coping:Theory, Research and Application.* Westport: Praeger.

Folkman, S.K., and Lazarus, R.S., (1980). An Analysis of Coping in a Middle Aged Community Sample. *Journal of Health and Social Behavior,* **21,** p 219-239.

Folkman, S.K., and Moskowitz, J.T., (2000). Positive Affect and the Other Side of Coping. *American Psychologist,* **55(6),** p 647-654.

Frazier, P.A., Tix, A.P., Klein, C.D., and Arikian, N.J., (2000). Testing Theoretical Models of the Relations Between Social Support, Coping, and Adjustment to Stressful Life Events. *Journal of Social and Clinical Psychology,* **19(3),** p 314-335.

Frese, M., (1999). Social Support as a Moderator of the Relationship Between Work Stressors and Psychological Dysfunctioning: A Longitudinal Study with Objective Measures. *Journal of Occupational Health Psychology,* **4(3),** p 179-192.

Freud, S., (1937). Analysis Terminable and Interminable. In, *Standard Edition of the Complete Psychological Works of Sigmund Freud,* **Vol. 23.** London: Hogarth Press.

Friedman, E.S., Clark, D.B., and Gershon, S., (1992). Stress, Anxiety, and Depression: Review of Biological, Diagnostic, and Nosologic Issues. *Journal of Anxiety Disorders,* **6,** p 337-363.

Garfield, S. and Bergin, A., (1971). Personal Therapy, Outcome and Some Therapist Variables. *Psychotherapy: Theory, Research, and Practice,* **8,** p 251-253.

Glidden, C.E., and Tracey, T.J., (1992). A Multidimensional Scaling Analysis of Supervisory Dimensions and their Perceived Relevance Across Trainee Experience Levels. *Professional Psychology: Research and Practice,* **23,** p 151-157.

Goldberg, D.P., (1972). *The Detection of Psychiatric Illness by Questionnaire.* London: Oxford University Press.

Goldberg, D.P., Gater, R., Sartorius, N., Ustun, T.B., Piccinelli, M., Gureje, O., and Rutter, C., (1997). The Validity of Two Versions of the GHQ in the WHO Study of Mental Illness in General Health Care. *Psychological Medicine,* **27,** p 191-197.

Goldberg, D.P., and Hillier, V.F., (1979). A Scaled Version of the General Health Questionnaire. *Psychological Medicine,* **9,** p 139-145.

Goldberg, D.P., Oldehinkel, T., and Ormel, J., (1998). Why GHQ Threshold Varies from One Place to Another. *Psychological Medicine,* **28,** p 915-921.

Goldstein, A.P., and Kanfer, F.H. (Eds.), (1979). *Maximising Treatment Gains: Transfer Enhancement in Psychotherapy.* New York: Academic Press.

Goodyer, I.M., Kolvin, I., and Gatzanis, S., (1987). The Impact of Recent Undesirable Life Events on Psychiatric Disorders in Childhood and Adolescence. *British Journal of Psychiatry,* **151,** p 179-184.

Greene, J., and D'Oliveira, M., (1982). *Learning to Use Statistical Tests in Psychology.* Milton Keynes: Open University Press.

Gunnar, M.R., (1992). Reactivity of the Hypothalamic-Pituitary-Adrenocortical System to Stressors in Normal Infants and Children. *Paediatrics,* **90,** p 491-497.

Guy, J.D., (1987). *The Personal Life of the Psychotherapist.* New York: John Wiley and Sons.

Guy, J.D., and Liaboe, G.P., (1985). Suicide among Psychotherapists: Review and Discussion. *Professional Psychology: Research and Practice,* **16,** p 470-472.

Guy, J.D., Poelstra, P.L., and Stark, M.J., (1989). Personal Distress and Therapeutic Effectiveness: National Survey of Psychologists Practicing Psychotherapy. *Professional Psychology: Research and Practice,* **20(1),** p 48-50.

Halgin, R.P., and Murphy, R.A. (1995). Issues in the Training of Psychotherapists. In, Bongar, B., and Beutler, L.E., (Eds.), *Comprehensive Textbook of Psychotherapy.* Oxford: Oxford University Press.

Harrison, R.V., (1978). Person - Environment fit and job stress. In, Copper, C.L. and Payne, R., (Eds.) *Stress at Work*, New York: Wiley.

Heller, K., (1979). The Effects of Social Support: Prevention and Treatment Implications. In, Goldstein, A.P., and Kanfer, F.H. (Eds.), *Maximising Treatment Gains: Transfer Enhancement in Psychotherapy.* New York: Academic Press.

Heller, K., Swindle Jr., R.W., and Dusenbury, L., (1986). Component Social Support Processes: Comments and Integration. *Journal of Consulting and Clinical Psychology,* **54(4),** p 466-470.

Hess, A.K., (Ed.), (1980). *Psychotherapy Supervision: Theory, Research and Practice.* New York: Wiley.

Hingley, S.M., (2001). Psychodynamic Theory and Narcissistically Related Personality Problems: Support From Case Study Research. *British Journal of Medical Psychology,* **74,** p 57-72.

Holahan, C.J., Moos, R.H., Holahan, C.K., and Brennan, P.L., (1995). Social Support, Coping, and Depressive Symptoms in a Late Middle Aged Sample of Patients Reporting Cardiac Illness. *Health Psychology,* **14,** p 152-163.

Horowitz, L.M., Krasnoperova, E.N., Tatar, D.G., Hansen, M.B., Person, E.A., Galvin, K.L., and Nelson, K.L., (2001). The Way to Console May Depend on the Goal: Experimental Studies of Social Support. *Journal of Experimental Psychology,* **37,** p 49-61.

House, J.S., Landis, K.R., and Umberson, D., (1988). Social Relationships and Health. *Science,* **241 (July 29),** p 540-545.

Insel, P., and Moos, R.H. (Eds.), (1974). *Health and the Social Environment.* Lexington, MA: Heath.

International Psychoanalytical Association, (1999). *An Open Door Review of Outcome Studies in Psychoanalysis.* London: University College London.

Kapur, N., (2000). Helping Members (letter). *The Psychologist,* **13(12),** p 596.

Kapur, N., (2001). Personal Communication to Author.

Kendler, K.S., Karkowski, L.M., and Prescott, C.A., (1999). Causal Relationships Between Stressful Life Events and the Onset of Major Depression. *American Journal of Psychiatry,* **156,** p 837-841.

Kernberg, O.F., (1984). *Object Relations Theory and Clinical Psychoanalysis.* London: Jason Aronson.

Kessler, R.C., (1997). The Effects of Stressful Life Events on Depression. *Annual Review of Psychology,* **48,** p 191-214.

Kobasa, S.C., (1979). Stressful Life Events, Personality, and Health: An Inquiry Into Hardiness. *Journal of Personality and Social Psychology,* **37,** p 1-11.

Kopta, S.M., Lueger, R.J., Saunders, S.M., and Howard, K.I., (1999). Individual Psychotherapy Outcome and Process Research: Challenges Leading to Greater Turmoil or a Positive Transition? *Annual Review of Psychology,* **50,** p 441-469.

Kuipers, L. (1995). Expressed Emotion: Measurement, Intervention, and Training Issues. In, Brugha, T.S. (Ed.), *Social Support and Psychiatric Disorder. Research Findings and Guidelines for Clinical Practice.* Cambridge: Cambridge University Press.

Kuyken, W., Peters, E., Power, M., and Lavender, T., (1998). The Psychological Adaption of Psychologists in Clinical Training: The Role of Cognition, Coping and Social Support. *Clinical Psychology and Psychotherapy,* **5**, p 238-252.

Kuyken, W., Peters, E., Power, M., Lavender, T., and Rabe-Hesketh, S., (2000). A Longitudinal Study of the Psychological Adaptation of Trainee Clinical Psychologists. *Clinical Psychology and Psychotherapy,* **7**, p 394-400.

Laireter, A., and Baumann, U., (1988). Klinish-psychologishe Soziodiagnostik: Protektive Variablen und Soziale Anpassung. *Diagnostica,* **34,** p 190-226.

Laireter, A., and Baumann, U., (1992). Network Structures and Support Functions - Theoretical and Empirical Analyses. In, Veiel, H.O.F., and Baumann, U. (Eds.), *The Meaning and Measurement of Social Support.* New York: Hemispshere Publishing Corporation.

Laliotis, D.A., and Grayson, J.H., (1985). Psychologist Heal Thyself - What is Available for the Impaired Psychologist ?. *American Psychologist,* **40(1),** p 84-96.

Lam, D.H., and Power, M., (1991). A Questionnaire Designed to Assess Roles and Goals: A Preliminary Study. *British Journal of Medical Psychology,* **64,** p 359-373.

Lamb, D.H., Presser, N.R., Pfost, K.S., Baum, M.C., Jackson, V.R., and Jarvis, P.A., (1987). Confronting Professional Impairment During the Internship: Identification, Due Process, and Remediation. *Professional Psychology: Research and Practice,* **18(6),** p 597-603.

Laliotis, D.A., and Grayson, J.H., (1985). Psychologist Heal Thyself. *American Psychologist,* **40(1),** p 84-96.

Lambert, M.J., and Bergin, A.E., (1994). The Effectiveness of Psychotherapy. In, Bergin, S.L., and Garfield, S.L. (Eds.), *Handbook of Psychotherapy and Behavior Change,* 4th Ed., New York: Wiley.

Latack, J.C., and Havolovic, S.J., (1992). Coping with Job Stress: A Conceptual Evaluation Framework for Coping Measures. *Journal of Organizational Behavior,* **13,** p 479-508.

Lazarus, R.S., (1966). *Psychological Stress and the Coping Process.* New York: McGraw-Hill.

Lazarus, R.S., (1993). Coping Theory and Research: Past Present and Future. *Psychosomatic Medicine,* **55,** p 234-247.

Lazarus, R.S., (2000). Toward Better Research on Stress and Coping. *American Psychologist,* **55(6),** p 665-673.

Lazarus, R.S., and Folkman, S., (1984). *Stress, Appraisal, and Coping.* New York: Springer.

Lazarus, R.S., and Smith, C.A., (1988). Knowledge and Appraisal in the Cognition-Emotion Relationship. *Cognition and Emotion,* **2,** p 281-300.

Lewinsohn, P.M., Hoberman, H.M., and Rosenbaum, M., (1988). A Prospective Study of Risk Factors for Unipolar Depression. *Journal of Abnormal Psychology,* **97,** p 251-264.

Liddell, A., (1983a). Professional Development. In, Liddell, A. (Ed.), *The Practice of Clinical Psychology in Great Britain.* Chichester: John Wiley.

Liddell, A., (1983b). The Training and Function of a Clinical Psychologist. In, Liddell, A. (Ed.), *The Practice of Clinical Psychology in Great Britain.* Chichester: John Wiley.

Lindsay, S.J.E., and Powell, G.E. (Eds.), (1994). *Clinical Adult Psychology* (2nd ed.). London: Routledge.

Lloyd, C., (1995). Understanding Social Support Within the Context of Theory and Research on the Relationship of Life Stress and Mental Health. In, Brugha, T.S. (Ed.), *Social Support and Psychiatric Disorder. Research Findings and Guidelines for Clinical Practice.* Cambridge: Cambridge University Press.

Long, C.G., and Hollin, C.R., (1997). The Scientist Practitioner Model in Clinical Psychology: A Critique. *Clinical Psychology and Psychotherapy,* **4(2),** p 75-83.

MacCaskill, A., (1999). Personal Therapy as a Training Requirement: The Lack of Supporting Evidence. In, Feltham, C. (Ed.), *Controversies in Psychotherapy and Counselling.* London: Sage Publications.

MacCaskill, N.D., (1988). Personal Therapy in the Training of the Psychotherapist: Is it Effective? *British Journal of Psychotherapy,* **4(3),** p 219-226.

MacCaskill, N., and MacCaskill, A., (1992). Psychotherapists-In-Training Evaluate Their Personal Therapy: Results of a UK Survey. *British Journal of Psychotherapy,* **9(2),** p 133-138.

Macran, S., and Shapiro, D.A., (1998). The Role of Personal Therapy for Therapists: A Review. *British Journal of Medical Psychology,* **71,** p 13-25.

Malan, D.H., (1995). *Individual Psychotherapy and the Science of Psychodynamics.* (2nd Ed.). Oxford: Butterworth-Heinemann.

Marston, A.R., (1984). What Makes Therapists Run? A Model for Analysis of Motivational Styles. *Psychotherapy,* **21,** p 456-459.

Maslach, C., (1982). *Burn-out - The Cost of Caring.* Englewod, Cliffs. NJ: Prentice Hall.

Maslach, C., and Jackson, S.E., (1981). The Measurement of Experienced Burnout. *Journal of Occupational Behavior,* **2,** p 99-113.

Maslach, C., Schaufeli, W.B., and Leiter, M.P., (2001). Job Burnout. *Annual Review of Psychology,* **52,** p 397-422.

McCarthy, P., Kulakowski, D., and Kenfield, J.A., (1994). Clinical Supervision Practices of Licensed Psychologists. *Professional Psychology: Research and Practice,* **25(2),** p 177-181.

McLennan, J., (1999). Becoming an Effective Psychotherapist or Counsellor: Are Training and Supervision Necessary? In, Feltham, C. (Ed.), *Controversies in Psychotherapy and Counselling.* London: Sage Publications.

Mehrota, S, Rao, K, and Subbakrishna, D.K., (2000). Factor Structure of The Mental Health Professionals Stress Scale (MHPSS) Among Clinical Psychologists in India. *International Journal of Social Psychiatry,* **46(2),** p 142-150.

Miller, R., (1990). The Role of the DCP in Continuing Professional Development (CPD). *Clinical Psychology Forum,* **28,** p 36-37.

Miller, S.M., (1992). Individual Differences in the Coping Process: What to Know and When to Know it. In, Carpenter, B.N. (Ed.), *Personal Coping: Theory, Research and Application.* Westport: Praeger.

Miller, W.L., and Crabtree, B.F., (1998). Clinical Research. In, Denzin, N.K., and Lincoln, Y.S., (Eds.), *Strategies of Qualitative Inquiry.* Lincoln: Sage.

Milne, D., (1998). Clinical Supervision: Time to Reconstruct or to Retrench?. *Clinical Psychology and Psychotherapy,* **5,** p 199-203.

Mitchell, J.C. (Ed.), (1969). *Social Networks in Urban Situations.* Manchester: Manchester University Press.

Mitchell, J. (Ed.), (1986). *The Selected Melanie Klein.* Harmondsworth: Penguin.

Monroe, S.M., Bromet, E.J., Connel, M.M., and Steiner, S.C., (1986). Social Support, Life Events, and Depressive Symptoms: A 1-Year Prospective Study. *Journal of Consulting and Clinical Psychology,* **54(4),** p 424-431.

Monroe, S.M., Harkness, K., Simons, A.D., and Thase, M.E., (2001). Life Stress and the Symptoms of Depression. *The Journal of Nervous and Mental Disease,* **180(3),** p 168-175.

Moore, K.A., and Cooper, C.L., (1996). Stress in Mental Health Professionals: A Theoretical Overview. *International Journal of Social Psychiatry,* **42(2),** p 82-89.

Murphy, E., (1982). Social Origins of Depression in Old Age. *British Journal of Psychiatry,* **141,** p 135-142.

Murtagh, M.P., and Wollersheim, J.P., (1997). Effects of Clinical Practice on Psychologists: Treating Depressed Clients, Perceived Stress, and Ways of Coping. *Professional Psychology: Research and Practice,* **28(4),** p 361-364.

Napier, B., (1995). Clinical Psychology. In, British Psychological Society. *Professional Psychology Handbook.* Leicester: BPS Books.

Nichols, K.A., (1988). Practising What We Preach. *The Psychologist,* **1,** p 50-51.

Newton, T.J., (1989). Occupational Stress and Coping with Stress: A Critique. *Human Relations,* **42,** p 441-461.

Norcross, J.C., (1988). Supervision of Integrative Psychotherapy. *Journal of Integrative and Eclectic Psychotherapy,* **7,** p 157-166.

Norcross, J.C., (1990). Personal Therapy for Therapists: One Solution. *Psychotherapy in Private Practice,* **8(1),** p 45-51.

Norcross, J.C., and Prochaska, J.O., (1986). Psychotherapist Heal Thyself II. The Self Initiated and Therapy Facilitated Change of Psychological Distress. *Psychotherapy,* **23(3),** p 345-356.

Oakland, S., and Ostell, A., (1996). Measuring Coping: A Review and Critique. *Human Relations,* **49(2),** p 133-155.

Parker, J.D.A, and Endler, N.S., (1992). Coping with Coping Assessment: A Critical Review. *European Journal of Personality,* **6,** p 321-344.

Patterson, T.L., Smith, L.W., Grant, I., Clopton, P., Josepho, S., and Yager, J., (1990). Internal vs. External Determinants of Coping Responses to Stressful Life Events in the Elderly. *British Journal of Medical Psychology,* **63,** p 149-160.

Paykel, E.S., (1994). Life Events , Social Support, and Depression. *Acta Psychiatra Scandanavica,* **Suppl. 377,** p 50-58.

Paykel, E.S., (2001). Stress and Affective Disorders in Humans. *Seminars in Clinical Neuropsychiatry,* **6(1),** p 4-11.

Pedhazur, E.J., (1982). *Multiple Regression in Behavioural Research: Explanation and Prediction* (2nd Ed.). Fort-Worth, Texas: Holt, Reinhart, and Winston Inc.

Pengilly, J.W., and Dowd, T.E., (2000). Hardiness and Social Support as Moderators of Stress. *Journal of Clinical Psychology,* **56(6),** p 813-820.

Pitts, M. and Phillips, K. (Eds.), (1995). *The Psychology of Health: An Introduction.* London: Routledge.

Pope, K.S., and Tabachnick, B.G., (1994). Therapists as Patients: A National Survey of Psychologists' Experiences, Problems, and Beliefs. *Professional Psychology: Research and Practice,* **25(3),** p 247-258.

Power, M.J., (1988). Stress Buffering Effects of Social Support: A Longitudinal Study. *Motivation and Emotion,* **12,** p 197-204.

Power, M.J., and Champion, L.A., (1992). The Significant Others Scale (SOS). In, Milne, D. (Ed.), *A Mental Health Assessment Resource Pack.* Windsor: NFER-Nelson.

Power, M.J., Champion, L.A., and Aris, S.J., (1988). The Development of a Measure of Social Support: The Significant Others Scale. *British Journal of Clinical Psychology,* **27**, p 349-358.

Power, M.J., and Dalgleish, T., (1997). *Cognition and Emotion. From Order to Disorder.* Hove: Psychology Press.

Price, R.H., (1974). Etiology, The Social Environment, and the Prevention of Psychological Dysfunction. In, Insel, P., and Moos, R.H. (Eds.), *Health and the Social Environment.* Lexington, MA: Heath.

Prochaska, J.O., and Norcross, J.C., (1983). Psychotherapists' Perspectives on Treating Themselves and Their Clients for Psychic Distress. *Professional Psychology: Research and Practice,* **14(5),** p 642-655.

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P., and Thornicroft, G., (1997). Perceived Sources of Work Stress and Satisfaction Among Hospital and

Community Mental Health Staff, and their Relation to Mental Health, Burnout and Job Satisfaction. *Journal of Psychosomatic Research,* **43(1),** p 51-59.

Raquepaw, J.M., and Miller, R.S., (1989). Psychotherapist Burnout: A Componential Analysis. *Professional Psychology: Research and Practice,* **20(1),** p32-36.

Reamer, F.G., (1992). The Impaired Social Worker. *Social Work,* **37(2),** p 165-170.

Rees, D., and Cooper, C.L., (1992). Occupational Stress in Health Service Workers in the UK. *Stress Medicine,* **8,** p 79-90.

Reisman, J.M., (1981). History and Current Trends in Clinical Psychology. In, Walker, C.E. (Ed.), *Clinical Practice of Psychology: A Guide for Mental Health Professionals.* New York: Pergamon Press.

Rodolfa, E.R., Haynes, S., Kaplan, D., Chamberlain, M., Goh, M., Marquis, P., and McBride, L., (1998). Supervisory Practices of Psychologists - Does Time Since Licensure Matter? *The Clinical Supervisor,* **17(2),** p 177-183.

Roth, A., and Fonagy, P., (1996). *What Works for Whom: Limitations and Implications of the Research Literature.* New York: Guilford Press.

Sampson, J., (1991). Stress Survey of Clinical Psychologists in Scotland, 1989. *British Psychological Society Scottish Branch Newsletter,* **11,** p 11-14.

Sarason, I.G., Johnson, J.H., and Siegel, J.M., (1978). Assessing the Impact of Life Changes: Development of the Life Experiences Survey. *Journal of Consulting and Clinical Psychology,* **48,** p 932-946.

Schaufeli, W.B., and Enzmann, D., (1998). *The Burnout Companion to Study and Practice: A Critical Analysis.* Philadelphia: Taylor and Francis.

Schwarzer, R., and Leppin, A., (1991). Social Support and Health: A Theoretical and Empirical Overview. *Journal of Social and Personal Relationships,* **8,** p 99-127.

Scolnick, A., (1986). Early Attachment and Personal Relationships Across the Life Course. In, Baltes, P.B., Featherman, L., and Lener, R.M., (Eds.), *Life-span Development and Behavior,* Vol. 7. Hillsdale, N.J.:Lawrence Erlbaum.

Scottish Council for Postgraduate Medical and Dental Education (SCPDME), (1999). *Psychology Services in Scottish Healthcare.* Review commissioned jointly by, The Scottish Council for Postgraduate Medical and Dental Education (SCPDME), and, Clinical and Applied Psychologists in Scottish Healthcare (CAPISH). Edinburgh: SCPDME.

Seligman, M.E.F, (1975). *Helplessness.* San Francisco: Foreman.

Shapiro, S.L., Shapiro, D.E., and Schwartz, G.E.R., (2000). Stress Management in Medical Education: A Review of the Literature. *Academic Medicine,* **75(7),** p 748-759.

Shinn, M., Rosario, M., Morch, H., and Chestnut, D.E., (1984). Coping With Job Stress and Burnout in the Human Services. *Journal of Personality and Social Psychology,* **46,** p 864-876.

Sherman, M.D., (1996). Distress and Professional Impairment due to Mental Health Problems among Psychotherapists, *Clinical Psychology Review,* **16(4),** p 299-315.

Sherman, M.D., and Thelen, M.H., (1998). Distress and Professional Impairment Among Psychologists in Clinical Practice. *Professional Psychology: Research and Practice,* **29(1),** p 79-85.

Sinason, V., (1999). In Defence of Therapy for Training. In, Feltham, C. (Ed.), *Controversies in Psychotherapy and Counselling.* London: Sage Publications.

Skolnick, A., (1986). Early Attachment and Personal Relationships Across the Life Course. In, Baltes, P.B., Featheman, D.L., and Lerner, R.M. (Eds.), *Life Span Development and Behaviour, Vol. 7,* Hillsdale, N.J.: Lawrence.

Smith, C.A., and Ellsworth, P.C., (1987). Patterns of Cognitive Appraisal and Emotion Related to Taking an Exam. *Journal of Personality and Social Psychology,* **52,** p 475-488.

SPSS Incorporated, (1989-2000). Statistical Package for the Social Sciences. Release 10.0.1.

Stricker, G., (1988). Supervision of Integrative Psychotherapy: Discussion. *Journal of Integrative and Eclectic Psychotherapy,* **7,** p 176-180.

Suls, J., and David, J.P., (1996). Coping and Personality: Third Time's the Charm? *Journal of Personality,* **64(4),** p 993-1005.

Suls, J., David, J.P., and Harvey, J.H., (1996). Personality and Coping: Three Generations of Research. *Journal of Personality,* **64(4),** p 711-735.

Thoits, P.A., (1986). Social Support as Coping Assistance. *Journal of Consulting and Clinical Psychology,* **54(4),** p 416-423.

Thoreson, R.W., Miller, M., and Krauskopf, C.J., (1989). The Distressed Psychologist: Prevalence and Treatment Considerations. *Professional Psychology: Research and Practice,* **20(3),** p 153-158.

Uchino, B.N., Cacioppo, J.T., and Kiecolt-Glaser, J.K., (1996). The Relationship Between Social Support and Physiological Processes: A Review With Emphasis on

Underlying Mechanisms and Implications for Health. *Psychological Bulletin*, **119(3),** p 488-531.

Uchino, B.N., Uno, D., and Holt-Lunstad, J., (1999). Social Support, Physiological Processes, and Health. *Current Directions in Psychological Science,* **8(5),** p 145-148.

Van Os, J., and Jones, P.B., (1999). Early Risk Factors and Adult Person-Environment Relationships in Affective Disorder. *Psychological Medicine,* **29**, p 1055-1068.

Vermeulen, M., and Mustard, C., (2000). Gender Differences in Job Strain, Social Support at Work, and Psychological Distress. *Journal of Occupational Health Psychology,* **5(4),** p 428-440.

Viswesvaran, C., Sanchez, J.I., Fisher, J., (1999). The Role of Social Support in the Process of Work Stress: A Meta-Analysis. *Journal of Vocational Behavior,* **54,** p 314-334.

Vredenburgh, L.D., Carlozzi, A.F., and Stein, L.B., (1999). Burnout in Counseling Psychologists: Type of Practice Setting and Pertinent Demographics. *Counselling Psychology Quarterly,* **12(3),** p 293-302.

Walsh, S., and Cormack, M., (1994). 'Do as We Say But Not as We Do': Organisational, Professional and Personal Barriers to the Receipt of Support at Work. *Clinical Psychology and Psychotherapy,* **1(2),** p 101-110.

Wampold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K., and Hyun-nie, A., (1997). A Meta Analysis of Outcome Studies Comparing Bona Fide Psychotherapies: Empirically, "All Must Have Prizes". *Psychological Bulletin,* **122(3),** p 203-215.

Watkins, C.E., (1983). Counseling Psychology Versus Clinical Psychology: Further Explorations on a Theme, or, Once More Around the "Identity" Maypole With Gusto. *The Counseling Psychologist,* **11(4),** p 76-92.

Watkins, C.E., (1990). Development of the Psychotherapy Supervisor. *Psychotherapy,* **27,** p 553-560.

Watkins, C.E., (1997). The Ineffective Supervisor: Some Reflections About Bad Behaviours, Poor Process, and Offensive Outcomes. *The Clinical Supervisor,* **16(1),** p 163-180.

Watson, D. and Hubbard, B., (1996). Adaptional Style and Dispositional Structure: Coping in the Context of the Five Factor Model. *Journal of Personality,* **64,** p 737-774.

Witmer, L., (1907). Clinical Psychology. *Psychological Clinic,* **1**, p 1-9.

Zeidner, M., and Endler, N. (Eds.), (1996). *Handbook of Coping.* New York: Wiley.

Zemirah, N.L., (2000). Burnout and Clinical Psychology Graduate Students: A Qualitative Study of Student's Experiences and Perceptions. *Dissertation Abstracts International: Section B: The Sciences and Engineering,* **60(10B),** 5237.

Zook II, A., and Walton, J.M., (1989). Theoretical Orientations and Work Settings of Clinical and Counseling Psychologists: A Current Perspective. *Professional Psychology: Research and Practice,* **20(1),** p 23-31.

Appendices

Doctorate in Clinical Psychology
Research Protocol

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Title:

Stress and Mental Health among Clinical Psychologists: Its Relationship to Professional and Social Support, Coping Style, and Individual Demographics.

Introduction:

The experience of stress by an individual can be conceptualised as a complex bio-psychosocial response that results from interactions between life stressors, the individuals personal and environmental resources, and his or her cognitive appraisals and coping styles. Stress can manifest itself in varied ways in an individual, of which anxiety and affective disorders are the primary pathological representations (Friedman, Clark, and Gershon, 1992). Lazarus' (1993) transactional model of stress suggests that the coping with stress comprises a process of appraisal of the stressor, and an appraisal of the personal and contextual resources available to the individual, leading to the adoption of a particular coping strategy. The amount of stress experienced will be a result of the 'goodness of fit' between the stressor and the coping strategy adopted. Inherent in this model is the idea that the availability of personal and contextual resources is a key component in the level of stress a person may experience in the face of a stressor.

The presence of support from other individuals has been described as one such resource which can alter the relationship between stressor and amount of stress experienced by an individual. Cohen and Wills (1985) describe how social support can be viewed either as having a direct or main effect on psychological well being, or as acting as a moderating variable or buffer between stressors and experienced stress. In a review of studies examining stress and social support, they reported finding evidence for both models. As a main effect, social support could create well-being through providing consistent and frequent positive experiences for an individual as well as a sense of belong within an established system. As a moderating variable, social support could effect both the stressor appraisal and the appraisal of resources stages of coping with stress. Through the provision emotional, informational and practical support the presence of social support in an individuals life could buffer against stress.

Stress in mental health workers is an important area to study for a number of reasons. Firstly, work stress can impact negatively upon the patients under the individuals care. Guy, Poelstra, and Stark (1989) found that 74.3% of a representative population of psychologists reported

experiencing stress at work, and that 36.7% of those reported that the stress had a negative impact on the care they delivered. Secondly, any professional impairment occurring as a result of stress could have knock on effects for the profession in general, the public's impression of the profession, and the effected practitioners colleagues (Sherman, 1996). Thirdly, stress can have severe personal consequences for the sufferer, and in the case of mental health workers it has been argued that they may represent an already vulnerable group (Guy, 1987) who may choose not to seek help for a number of reasons (Nichols, 1988). Furthermore it has been argues that mental health workers, as a result of the work that they do, may encounter more stressors, for example in the form of patient violence, or projected emotional pain, compared to a normal population (Walsh and Cormack, 1994).
There is a growing body of evidence suggesting that clinical psychologists do experience high levels of work related stress, and that this stress is related to the amount of social support they perceive themselves to have (e.g. Cushway, Tyler, and Nolan, 1996). Less notice has been given to the relationship between the levels of professional support, formal or otherwise, and work related stress in this population. On the face of it this would seem an important area to investigate given that fellow professionals may be in the best position to provide the resources outlined by Cohen and Wills (1985), that could serve to moderate the stress experienced by an individual at work. Such an idea has gained some supportive evidence from a study by Coster and Schwebel (1997) in which psychologists placed professional support, clinical supervision, and personal therapy as the most important factors in their maintenance of well being.

Aims and Hypotheses of Study:

The first aim of the study is to build on the growing literature examining experiences of stress and mental health among clinical psychologists, by investigating the prevalence of psychopathology and work stressors in a representative group.

A second aim of the study is to explicitly examine the relationship between availability and satisfaction with professional support as a moderating factor between stressors and experienced stress among clinical psychologists.

A third aim of the study is to examine correlations between scores on psychopathology and scores on measures of social support, coping style and non-work related stressors.

A fourth aim of the study is to examine to what extent the measured variables moderate the relationship between stressful events and psychopathology.

A hypothesis of the study would be that higher levels professional support would cause less experienced psychopathology in the sample.

A second hypothesis would be that higher levels of satisfaction with available support would predict lower levels psychopathology.

A third hypothesis would state availability and satisfaction wit professional support resources would be a major moderator between stressors and experienced psychopathology.

Methods:

Subjects: Subjects will be clinical psychologists identified as working within a defined area of Scotland, from the national register of psychologists.

Design: The design is mixed, containing a within and between groups design with psychopathology, stress, coping style, and social and professional support being examined in a group of clinical psychologists, and a correlational design between measured variables.

The dependent variable is level of psychopathology, with the independent variables being levels of work specific and other life stressors.
Moderating variables measured will be professional and non-professional social support, and coping style.
Between group variables will be factors such as sex, years of qualified practice, and area of work (specialism).
Data gathered will be cross sectional, recruiting participants at one time point.

Measures: **The Brief Symptom Inventory** (Derogatis, 1993) will be used to measure psychopathology.

The Mental Health Professional Stress Scale (Cushway *et al.*, 1996) will be used to measure work stress.

The **Life Experiences Survey** (Sarason, Johnson and Siegel, 1978) will be used to measure stressful life events.

Modified versions of the **Significant Others Scale** (Power, Champion and Aris, 1988) will be used to assess satisfaction with professional support and social support.

A coping style questionnaire of the type described by Cushway *et al.* (1996) will be used to measure coping style.

A demographic assessment sheet will be used to measure demographic variables and ask three to four open ended questions about work stress, it's effect on practice, and methods of stress alleviation

Procedure: Measures will be posted out to participants who will fill them in independently and return them to the researcher using an enclosed stamped addressed envelope.
Data will be collected from the returned forms and analysed in line with the design of the study.

Conclusions:

Conclusions could be drawn from the results of the study as to the relative importance of professional support in the work of the clinical psychologist.

References:

Cohen, S., and Wills, T.A., (1985). Stress, Social Support, and the Buffering Hypothesis. *Psychological Bulletin,* **98(2),** p 310-357.

Coster, J.S., and Schwebel, M., (1997). Well-Functioning in Professional Psychologists. *Professional Psychology: Research and Practice,* **28(1),** p 5-13.

Cushway, D., Tyler, P.A., and Nolan, P., (1996). Development of a Stress Scale for Mental Health Professionals. *British Journal of Clinical Psychology,* **35,** p 279-295.

Derogatis, L. (1993). *Brief Symptom Inventory: Administration, Scoring, and Procedures Manual.* Third Edition. Minneapolis: Author.

Friedman, E.S., Clark, D.B., and Gershon, S., (1992). Stress, Anxiety, and Depression: Review of Biological, Diagnostic, and Nosologic Issues. *Journal of Anxiety Disorders,* **6,** p 337-363.

Guy, J.D., (1987). *The Personal Life of the Psychotherapist.* New York: John Wiley and Sons.

Guy, J.D., Poelstra, P.L., and Stark, M.J., (1989). Personal Distress and Therapeutic Effectiveness: National Survey of Psychologists Practicing Psychotherapy. *Professional Psychology: Research and Practice,* **20(1),** p 48-50.

Lazarus, R.S., (1993). Coping Theory and Research: Past Present and Future. *Psychosomatic Medicine,* **55,** p 234-247.

Nichols, K.A., (1988). Practising What We Preach. *The Psychologist,* **1**, p 50-51.

Power, M.J., Champion, L.A., and Aris, S.J., (1988). The Development of a Measure of Social Support: The Significant Others Scale. *British Journal of Clinical Psychology,* **27**, p 349-358.

Sherman, M.D., (1996). Distress and Professional Impairment due to Mental Health Problems among Psychotherapists, *Clinical Psychology Review,* **16(4),** p 299-315.

Sarason, I.G., Johnson, J.H., and Siegel, J.M., (1978). Assessing the Impact of Life Changes: Development of the Life Experiences Survey. *Journal of Consulting and Clinical Psychology,* **48,** p 932-946.

Walsh, S., and Cormack, M., (1994). 'Do as We Say But Not as We Do': Organizational, Professional and Personal Barriers to the Receipt of Support at Work. *Clinical Psychology and Psychotherapy,* **1(2),** p 101-110.

Department of Psychology, University of Edinburgh,
Ethics Committee submission

Proposal Number **Date received** **Date of response**

SUMMARY OF PROPOSAL

1. Title
Stress and Mental Health among Clinical Psychologists: Its Relationship to Professional and Social Support, Coping Style, and Individual Demographics.

2. Names of investigators submitting the proposal
Adam Burley, Trainee Clinical Psychologist, Department of Psychotherapy, 40 Colinton Road, Edinburgh.

3. Objectives of the study
See attached expansion sheet.

4. Task for the participants
See attached expansion sheet.

5. Who will be the participants?
Subjects will be clinical psychologists identified as working within Scotland, from the British Psychological Society register of chartered psychologists.

6. How will they be recruited? Will subjects be paid?
Subjects will be recruited by a direct mailing. No payment will be offered for participation.

7. Will written permission be obtained from parents in studies with children?
Not applicable.

8. What will the participants be told about the project at the beginning?
Participants will be informed in a participant information letter of the main objectives of the study.

9. What will they be told at the end?
Participants will be supplied with a summary of the study findings at it's completion.

10. Will the participants be given their own results?
Participants will not be given individual results on completion of the study.

11. Will the participants be given a general group result summary?
Yes.

12. Does the applicant undertake to preserve the anonymity of participants?
The identity of participants will be unknown to the researcher. The questionnaires will be filled in anonymously.

Indicate (by checking the boxes) which sets of ethical guidelines you have referred to in putting together
this submission (reference copies are in the Psychology Departmental library):

[ ] BPS code of conduct [ ] ASAB research on animal behaviour
[ ] MRC research on children [ ] MRC human participants /personal information
[ ] MRC use of animals [ ] MRC use of personal medical information
[ ] MRC AIDS vaccine trials [ ] MRC research on the mentally incapacitated
[ ] MRC medical research/publicising results [ ] Other: _____

12. Signature_____

Signature of Supervisor (Undergraduates/PGs) _____

Department of Psychology, University of Edinburgh,
Ethics Committee submission
Expansion Sheet

3. Objectives of the study

The first aim of the study is to build on the emerging literature examining experiences of stress and mental health among clinical psychologists, by investigating the prevalence of psychopathology and work stressors in a representative group.
A second aim of the study is to explicitly examine the relationship between availability and satisfaction with professional support as a moderating factor between stressors and experienced stress among clinical psychologists.
A third aim of the study is to examine correlations between scores on psychopathology and scores on measures of social support, coping style and non-work related stressors.
A fourth aim of the study is to examine to what extent the measured variables moderate the relationship between stressful events and psychopathology.
A hypothesis of the study would be that higher levels of professional support would be negatively correlated with experienced psychopathology in the sample.
A second hypothesis would be that higher levels of satisfaction with available support would be negatively correlated with experienced psychopathology.
A third hypothesis would state availability and satisfaction with professional support resources would be a major moderator between stressors and experienced psychopathology.

4. Task for the participants

Participants will be requested to complete the following set of self-report measures.
The Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983) will be used to measure psychopathology.
The Mental Health Professional Stress Scale (Cushway *et al.*, 1996) will be used to measure work stress.
The **Life Experiences Survey** (Sarason, Johnson and Siegel, 1978) will be used to measure stressful life events.
Modified versions of the **Significant Others Scale** (Power, Champion and Aris, 1988) will be used to assess satisfaction with professional support and social support.
A coping style questionnaire of the type described by Cushway *et al.* (1996) will be used to measure coping style.
A demographic assessment sheet will be used to measure demographic variables and ask three to four open ended questions about work stress, it's effect on practice, and methods of stress alleviation
Copies of the above measures are attached.
Measures will be posted out to participants who will fill them in independently and return them to the researcher using an enclosed stamped addressed envelope.

References

Cushway, D., Tyler, P.A., and Nolan, P., (1996). Development of a Stress Scale for Mental Health Professionals. *British Journal of Clinical Psychology,* **35,** p 279-295.
Power, M.J., Champion, L.A., and Aris, S.J., (1988). The Development of a Measure of Social Support: The Significant Others Scale. *British Journal of Clinical Psychology,* **27**, p 349-358.
Sarason, I.G., Johnson, J.H., and Siegel, J.M., (1978). Assessing the Impact of Life Changes: Development of the Life Experiences Survey. *Journal of Consulting and Clinical Psychology,* **48,** p 932-946.
Zigmond, A.S., and Snaith, R.P., (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica,* **67,** p 361-370.

Demographic Cover Sheet
(Tick, or write numbers in boxes)

1. Age in Years: ☐

2. Sex: Male ☐ Female ☐

3. Relationship Status: Single ☐ With Partner ☐

4. Years of Practice since Qualification: ☐

5. Hours of Work per Week: ☐

6. Major Specialism:

General Adult (Mental Health and Primary Care).	☐	General Physical Health / Health (other).	☐
Learning Disabilities.	☐	Older Adults.	☐
Children, Young People and Families.	☐	Alcohol and Substance Misuse.	☐
Forensic and Sex Offenders.	☐	HIV / AIDS	☐
Neuropsychology and Neurorehabilitation.	☐	Other.	☐

7. Major Theoretical Orientation:

Cognitive - Behavioural.	☐	Health Models.	☐
Humanistic.	☐	Neurospychology.	☐
Psychodynamic.	☐	Systems.	☐
Existential.	☐	Other.	☐

8. Do you receive regular Clinical Supervision? Yes ☐ No ☐ **If yes, how many hours per week?** ☐

9. Do you provide regular Clinical Supervision? Yes ☐ No ☐ **If yes, how many hours per week?** ☐

10. Do you have opportunities for regular continuing professional development? Yes ☐ No ☐ **If yes, how many hours per week?** ☐

11. Do you currently have your own personal therapy? Yes ☐ No ☐ **If yes, how many hours per week?** ☐

PTO ..../

Cont..

12. On average, how stressed would you say you are by your work? (circle one number)

Not at all Stressed		A Little Bit Stressed		Moderately Stressed		Very Stressed		Extremely Stressed
1	2	3	4	5	6	7	8	9

13. On average, how much would you say the stress you experience impairs your work? (circle one number)

Not at all		A Little Bit		Moderately		Very Much So		Extremely
1	2	3	4	5	6	7	8	9

14. (Optional) **What one or two things cause you the most stress at work?**

15. (Optional) **What one or two things do you think would make the work that you do less stressful?**

Mental Health Professionals Source of Pressure Scale

Tick one circle for each statement as it applies to you as a source of pressure at work.

0 = Does not apply to me. 1 = Applies to me a bit. 2 = Applies to me a lot. 3 = Applies to me always.

Sources of Pressure at Work	0	1	2	3
1. Too much work to do.	○	○	○	○
2. Terminating with clients.	○	○	○	○
3. Lack of support from management.	○	○	○	○
4. Conflict with other professions e.g. doctor, nurse.	○	○	○	○
5. Lack of adequate staffing.	○	○	○	○
6. Feeling inadequately skilled to deal with emotional needs of clients.	○	○	○	○
7. Not enough time with family.	○	○	○	○
8. Too many different things to do.	○	○	○	○
9. Dealing with death or suffering.	○	○	○	○
10. Relationship with line manager.	○	○	○	○
11. Conflicting roles with other professionals.	○	○	○	○
12. Lack of financal resources for training courses / workshops.	○	○	○	○
13. Uncertainty about own abilities.	○	○	○	○
14. Inability to seperate personal from professional role.	○	○	○	○
15. Not enough time to complete all tasks satisfactorily.	○	○	○	○
16. No change or slowness of change in clients.	○	○	○	○
17. Communications and flow of information at work.	○	○	○	○
18. Working in a multidisciplinary team.	○	○	○	○
19. Shortage of adequate equipment / supplies.	○	○	○	○
20. Feeling inadequately skilled for dealing with difficult clients.	○	○	○	○
21. Taking work home.	○	○	○	○
22. Too many clients / patients.	○	○	○	○
23. Difficult and/or demanding clients.	○	○	○	○
24. Poor management and supervision.	○	○	○	○
25. Criticism from other professional.	○	○	○	○
26. Lack of adequate cover in potentially dangerous environment.	○	○	○	○
27. Doubt about the efficacy of therapeutic endeavours.	○	○	○	○
28. Relationship with spouse / partner affects work.	○	○	○	○
29. Working too long hours.	○	○	○	○
30. Physically threatening clients.	○	○	○	○
31. The way conflicts are resolved in the organization.	○	○	○	○
32. Lack of emotional support from colleagues.	○	○	○	○
33. Inadequate clerical / technical backup.	○	○	○	○
34. Keeping professional / clinical skills up to date.	○	○	○	○
35. Work emphasises feelings of emptiness and/or isolation.	○	○	○	○
36. Not enough time for recreation.	○	○	○	○
37. Managing therapeutic relationships.	○	○	○	○
38. Organizational structure and policies.	○	○	○	○
39. Difficulty working with certain colleagues.	○	○	○	○
40. Poor physical working conditions.	○	○	○	○
41. Fear of making a mistake over a client's treatment.	○	○	○	○
42. Inadequate time for friendships / social relationships.	○	○	○	○

Life Events Scale

Tick one circle for each statement as it applies to you as a source of pressure outside of work.

0 = Does not apply to me. 1 = Applies to me a bit. 2 = Applies to me a lot. 3 = Applies to me always.

Sources of Pressure outside of Work	0	1	2	3
1. Death of spouse or partner.	❍	❍	❍	❍
2. Serious illness or injury of close family member.	❍	❍	❍	❍
3. Borrowing of a significant amount of money.	❍	❍	❍	❍
4. Major marital or relationship problems.	❍	❍	❍	❍
5. Change in spouse or partners work outside the home e.g. new job.	❍	❍	❍	❍
6. Son or daughter experiencing significant problems.	❍	❍	❍	❍
7. Major change in financial status (worse or better).	❍	❍	❍	❍
8. Death of other close family member.	❍	❍	❍	❍
9. Divorce.	❍	❍	❍	❍
10. Death of a close friend.	❍	❍	❍	❍
11. Minor law violation e.g. traffic conviction.	❍	❍	❍	❍
12. Son or daughter leaving home.	❍	❍	❍	❍
13. Major personal injury or illness.	❍	❍	❍	❍
14. Serious injury or illness of close friend.	❍	❍	❍	❍
15. New job.	❍	❍	❍	❍
16. Moving house.	❍	❍	❍	❍
17. Major change in living conditions.	❍	❍	❍	❍
18. Financial worries e.g. bills, mortgage.	❍	❍	❍	❍
19. Experience of personal trauma e.g. car crash, assault.	❍	❍	❍	❍
20. Major change in social situation.	❍	❍	❍	❍
Other recent experiences which have been sources of pressure outside of work. List and rate.				
21.	❍	❍	❍	❍
22.	❍	❍	❍	❍
23.	❍	❍	❍	❍
24.	❍	❍	❍	❍
25.	❍	❍	❍	❍

Significant Others Scale - Social (1)

Instructions

Listed below are various people who may be important in your life socially. For each person please circle a number from 1 to 7 to show how well he or she provides the type of help that is listed.

The second part of each question asks you to rate how you would like things to be if they were exactly as you hoped for. As before, please put a circle around one number between 1 and 7 to show what your rating is.

Note: If there is no such person in your life, leave the section blank and go on to the next.

Spouse (Husband / Wife) or Partner

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with him / her socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Mother

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with him / her socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Father

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with him / her socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Closest Brother or Sister

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with him / her socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Other Brother or Sister

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with him / her socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Closest Son or Daughter

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with him / her socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Best Friend

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with him / her socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Significant Others Scale - Social (2)

Instructions

Please list below up to seven people who are important in your life socially. Examples might be other friends, family members, religious figures, pets or social groups. For each one please circle a number from 1 to 7 to show how well they provide the type of help that is listed.

The second part of each question asks you to rate how you would like things to be if they were exactly as you hoped for. As before, please put a circle around one number between 1 and 7 to show what your rating is.

Note: You do not have to complete all seven sections.

Person / Group 1:

		Never		*Sometimes*				*Always*
1.	Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Do they give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with them socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 2:

		Never		*Sometimes*				*Always*
1.	Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Do they give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with them socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 3:

		Never		*Sometimes*				*Always*
1.	Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Do they give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with them socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Person / Group 4:

		Never			Sometimes			Always
1.	Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Do they give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with them socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 5:

		Never			Sometimes			Always
1.	Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Do they give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with them socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 6:

		Never			Sometimes			Always
1.	Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Do they give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with them socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 7.

		Never			Sometimes			Always
1.	Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does they give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Can you spend time with them socially ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Significant Others Scale - Professional (1)

Instructions

Listed below are various people who may be important in your professional life. For each one please circle a number from 1 to 7 to show how well they provide the type of help that is listed. (Categories differ from section to section)

The second part of each question asks you to rate how you would like things to be if they were exactly as you hoped for. As before, please put a circle around one number between 1 and 7 to show what your rating is.

Note: If there is no such person in your life, leave the section blank and go on to the next.

Clinical Supervisor

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Does this person help you develop new work skills ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Personal Therapist

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Does this person help you develop new work skills ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Boss / Head of Department

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Does this person help you develop new work skills ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Non-supervising Colleague

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Does this person help you develop new work skills ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Group Supervision

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does this group give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Does this group help you develop new work skills ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Other Colleague

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this person ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does he / she give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Does this person help you develop new work skills ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

Professional Development / Education Group

		Never			*Sometimes*			*Always*
1.	Can you trust, talk frankly and share you feelings with this group ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
2.	Can you lean on and turn to this group in times of difficulty?	1	2	3	4	5	6	7
	What rating would your ideal be?	1	2	3	4	5	6	7
3.	Does this group give you practical help ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7
4.	Does this group help you develop new work skills ?	1	2	3	4	5	6	7
	What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Significant Others Scale - Professional (2)

Instructions

Please list below up to seven people who are important in your professional life. Examples might be other colleagues, other professionals, or informal support groups. For each one please circle a number from 1 to 7 to show how they provide the type of help that is listed.

The second part of each question asks you to rate how you would like things to be if they were exactly as you hoped for. As before, please put a circle around one number between 1 and 7 to show what your rating is.

Note: You do not have to complete all seven sections.

Person / Group 1:

	Never			*Sometimes*			*Always*
1. Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
2. Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
What rating would your ideal be?	1	2	3	4	5	6	7
3. Do they give you practical help ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
4. Do they help you develop new work skills ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 2:

	Never			*Sometimes*			*Always*
1. Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
2. Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
What rating would your ideal be?	1	2	3	4	5	6	7
3. Do they give you practical help ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
4. Do they help you develop new work skills ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 3:

	Never			*Sometimes*			*Always*
1. Can you trust, talk frankly and share you feelings with this person / group?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
2. Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
What rating would your ideal be?	1	2	3	4	5	6	7
3. Do they give you practical help ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
4. Do they help you develop new work skills ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Person / Group 4:

	Never			*Sometimes*			*Always*
1. Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
2. Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
What rating would your ideal be?	1	2	3	4	5	6	7
3. Do they give you practical help ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
4. Do they help you develop new work skills ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 5:

	Never			*Sometimes*			*Always*
1. Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
2. Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
What rating would your ideal be?	1	2	3	4	5	6	7
3. Do they give you practical help ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
4. Do they help you develop new work skills ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 6:

	Never			*Sometimes*			*Always*
1. Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
2. Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
What rating would your ideal be?	1	2	3	4	5	6	7
3. Do they give you practical help ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
4. Do they help you develop new work skills ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7

Person / Group 7:

	Never			*Sometimes*			*Always*
1. Can you trust, talk frankly and share you feelings with this person / group ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
2. Can you lean on and turn to this person / group in times of difficulty?	1	2	3	4	5	6	7
What rating would your ideal be?	1	2	3	4	5	6	7
3. Do they give you practical help ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7
4. Do they help you develop new work skills ?	1	2	3	4	5	6	7
What rating would your ideal be ?	1	2	3	4	5	6	7

PLEASE CIRCLE ONLY ONE NUMBER FOR EACH QUESTION

Ways of Coping Scale

Thinking about one stressful situation you have experienced recently, read each item below and indicate by ticking one circle, to what extent you used that way of coping in that particular situation.

0 = Didn't Use. 1 = Used somewhat. 2 = Used quite a bit. 3 = Used a great deal.

Way of Coping	0	1	2	3
1. Concentrated on what I needed to do next - the next step.	○	○	○	○
2. Tried to get the person responsible to change his or her mind.	○	○	○	○
3. Talked to someone to find out more about the situation.	○	○	○	○
4. Criticised or lectured myself.	○	○	○	○
5. Tried not to burn my bridges, but left things open somewhat.	○	○	○	○
6. Went on as if nothing had happened.	○	○	○	○
7. Tried to keep my feelings to myself.	○	○	○	○
8. I expressed anger to the person(s) who had caused the problem.	○	○	○	○
9. Accepted sympathy and understanding from someone.	○	○	○	○
10. Tried to forget about the whole thing.	○	○	○	○
11. I apologised or did something to make up.	○	○	○	○
12. I made a plan of action and followed it.	○	○	○	○
13. I let my feelings out somehow.	○	○	○	○
14. Talked to someone who could do something concrete about the problem.	○	○	○	○
15. Tried to make myself feel better by eating, drinking, smoking, using drugs, or that sort of thing.	○	○	○	○
16. I tried not to act too hastily or follow my first hunch.	○	○	○	○
17. I found new faith.	○	○	○	○
18. I rediscovered what is important in life.	○	○	○	○
19. I changed something so that things woud turn out all right.	○	○	○	○
20. I avoided being with people in general.	○	○	○	○
21. I didn't let it get to me; refused to think too much about it.	○	○	○	○
22. I asked a relative or friend I respect for advice.	○	○	○	○
23. I kept others from knowing how bad things were.	○	○	○	○
24. Made light of the situation; refused to get too serious about it.	○	○	○	○
25. I talked to someone about how I was feeling.	○	○	○	○
26. Stood my ground and fought for what I wanted.	○	○	○	○
27. I knew what had to be done, so I doubled my efforts to make things work.	○	○	○	○
28. I made a promise to myself that things would be different next time.	○	○	○	○
29. I wished that the situation would go away or somehow be over with.	○	○	○	○
30. Had fantasies or wishes about how things would turn out.	○	○	○	○
31. I prayed.	○	○	○	○

General Health Questionnaire

Please circle the answer next to each statement that most nearly applies to you, when considering your health in general over the past few weeks.

Have you recently,

1. been feeling perfectly well and in good health?	Better than Usual	Same as Usual	Worse than Usual	Much Worse than Usual
2. been feeling in need of a good tonic?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
3. been feeling run down and out of sorts?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
4. felt that you are ill?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
5. been getting any pains in your head?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
6. 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
7. been having hot or cold spells?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
8. lost much sleep over worry?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
9. had difficulty in staying asleep once you are off?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
10. felt constantly under strain?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
11. been getting edgy and bad-tempered?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
12. been getting scared or panicky for no good reason?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
13. found everything getting on top of you?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
14. been feeling nervous and strung-up all the time?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
15. been managing to keep yourself busy and occupied?	More So than Usual	Same as Usual	Rather Less than Usual	Much Less than Usual
16. been taking longer over the things you do?	Quicker than Usual	Same as Usual	Longer than Usual	Much Longer than Usual
17. felt on the whole you were doing things well?	Better than Usual	About the Same	Less Well than Usual	Much Less Well
18. been satisfied with the way you've carried out your task?	More Satisfied	About the Same as Usual	Less Satisfied than Usual	Much Less Satisfied
19. felt that you're playing a useful part in things?	More So than Usual	Same as Usual	Less Useful than Usual	Much Less Useful
20. felt capable of making decisions about things?	More So than Usual	Same as Usual	Less So than Usual	Much Less Capable
21. 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
22. been thinking of yourself as a worthless person?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
23. felt that life is entirely hopeless?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
24. felt that life isn't worth living?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
25. thought of the possibility that you might make away with yourself?	Definitely Not	I Don't Think So	Has Crossed my Mind	Definitely Have
26. found at times you couldn't do anything because your nerves were to bad?	Not at All	No More than Usual	Rather More than Usual	Much More than Usual
27. 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
28. 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

PLEASE CIRCLE ONLY ONE ANSWER

Adam Burley
Clinical Psychologist in Training
Department of Psychotherapy
40 Colinton Road
Edinburgh
EH10 5BT

Tel: 0131 537 6926
e-mail: adamburley@adamshome.fsnet.co.uk

Dear

As part of my training in clinical psychology I am carrying out a survey of qualified clinical psychologists in Scotland in regards to their experiences of stressors at work, the satisfaction they feel with the level of support they receive in the face of those stressors, and their general health. Enclosed is a number of questionnaires that I am writing to you to ask you to complete for the purpose of this survey.

It has been argued that examining stress and support in our profession is an extremely important aspect of clinical governance for a number of reasons including; the impact that a psychologist's stress may have upon patient care, the impact that high levels of stress may have upon the professional themselves, and the effect such factors may have upon the public and purchasers image of the profession as a whole.

In an effort to maximise response rates and gain as true a picture as possible of the key variables the survey is **completely anonymous**, and a stamped addressed envelope is included for ease of return. Completion of the survey should take no longer than fourteen minutes, as although it may look like a lot of questions, the majority of them only require a tick in a box, and some sections are optional. I am aware that completing a questionnaire is only likely to add to the stress you experience at work, and so I have attempted to keep the survey as quick and easy to fill in as possible, and you don't have to fill it all in at once!

Your participation will be greatly appreciated and I will of course inform you of the results of the survey. In the meantime please do not hesitate to contact me directly if you have any questions about the project.

A brief summary of the questionnaires is printed overleaf.

Summary.... /

Summary of questionnaires:

Questionnaire	Measures	Average time to Complete
Demographic Sheet	Demographic Details.	2 minutes
Mental Health Professionals Source of Pressure Scale	Level of exposure to potential stressors at work.	3 minutes
Life Events Scale	Level of exposure to potential stressors outside of work.	2 minutes
Significant Others Scale - Social (1 + 2)	Presence and satisfaction with social supports.	2 - 4 minutes
Significant Others Scale - Professional (1 + 2)	Presence and satisfaction with professional supports.	2 - 4 minutes
Ways of Coping Scale	Methods of coping with stressors.	2 minutes
General Health Questionnaire	General health.	1 minute

Thank you very much for considering to participate.

The closing date for return of the survey is **Friday 15th June, 2001,** and I enclose a stamped addressed envelope for ease of return.

Many thanks again,

Yours sincerely,

Adam Burley
Clinical Psychologist in Training

Adam Burley
Clinical Psychologist in Training
Department of Psychotherapy
40 Colinton Road
Edinburgh
EH10 5BT

Tel: 0131 537 6926
e-mail: adamburley@adamshome.fsnet.co.uk

Date: 28th May 2001

Dear

You may remember that I wrote to you at the end of April asking for your participation in a survey of qualified clinical psychologists in Scotland in regards to their experiences of stressors at work, the satisfaction they feel with the level of support they receive in the face of those stressors, and their general health.

Due to the nature of the study I do not know who has or has not participated, but I am now writing to everyone to remind them of the closing date for return of the survey which is **Friday 15th June, 2001,** so that those who have not yet responded but would like to have a chance to participate.

You may be interested to know that the response rate for the study so far has been relatively good, and is at present at 45% (157 surveys), but of course some more wouldn't do any harm!

I also wanted to thank those that have returned the survey for taking the time to provide what I hope will turn out to be useful information, and of course a great assistance to the completion of my doctoral thesis. I greatly appreciated all responses, and particularly the words of encouragement and advice that accompanied many of them. Many thanks.

I am aware that some people may have misplaced the original survey and so replacement forms can be obtained anonymously from Sylvia Johnston, secretary at the Department of Psychotherapy at the address overleaf;

Address ...../

Address for ordering replacement survey forms,

Sylvia Johnston
Department of Psychotherapy
40 Colinton Road
Edinburgh
EH10 5BT

Tel: 0131 537 6926

Once again many thanks for your time and assistance with this project,

Yours sincerely,

Adam Burley
Clinical Psychologist in Training

Correlations

Correlations

		age in years	years of practice	work hpw	cpd hpm	therapy hpm	stress likert	impairment likert
age in years	Pearson Correlation	1.000	.899**	.022	-.088	-.079	.077	-.019
	Sig. (2-tailed)	.	.000	.769	.239	.292	.305	.804
	N	180	180	180	180	180	180	180
years of practice	Pearson Correlation	.899**	1.000	-.035	-.080	-.039	.015	-.073
	Sig. (2-tailed)	.000	.	.643	.284	.606	.837	.333
	N	180	180	180	180	180	180	180
work hpw	Pearson Correlation	.022	-.035	1.000	.071	.113	.133	.085
	Sig. (2-tailed)	.769	.643	.	.340	.129	.075	.256
	N	180	180	180	180	180	180	180
cpd hpm	Pearson Correlation	-.088	-.080	.071	1.000	.026	-.035	-.078
	Sig. (2-tailed)	.239	.284	.340	.	.728	.639	.301
	N	180	180	180	180	180	180	180
therapy hpm	Pearson Correlation	-.079	-.039	.113	.026	1.000	.011	.023
	Sig. (2-tailed)	.292	.606	.129	.728	.	.887	.760
	N	180	180	180	180	180	180	180
stress likert	Pearson Correlation	.077	.015	.133	-.035	.011	1.000	.749**
	Sig. (2-tailed)	.305	.837	.075	.639	.887	.	.000
	N	180	180	180	180	180	180	180
impairment likert	Pearson Correlation	-.019	-.073	.085	-.078	.023	.749**	1.000
	Sig. (2-tailed)	.804	.333	.256	.301	.760	.000	.
	N	180	180	180	180	180	180	180
ss total network	Pearson Correlation	-.051	-.097	-.084	.007	-.078	.007	.064
	Sig. (2-tailed)	.499	.197	.262	.925	.298	.930	.396
	N	180	180	180	180	180	180	180
ps total network	Pearson Correlation	-.052	-.069	.063	.090	-.038	.148*	.232**
	Sig. (2-tailed)	.490	.358	.398	.227	.609	.048	.002
	N	180	180	180	180	180	180	180
Workload	Pearson Correlation	.058	.024	.234**	-.101	.094	.528**	.401**
	Sig. (2-tailed)	.436	.748	.002	.176	.209	.000	.000
	N	180	180	180	180	180	180	180
Client-related difficulties	Pearson Correlation	-.203**	-.145	-.087	-.012	.163*	.225**	.295**
	Sig. (2-tailed)	.006	.053	.244	.870	.028	.002	.000
	N	180	180	180	180	180	180	180

Correlations

		age in years	years of practice	work hpw	cpd hpm	therapy hpm	stress likert	impairment likert
Organisational structure	Pearson Correlation	.127	.079	.060	-.077	-.007	.437**	.386**
	Sig. (2-tailed)	.090	.293	.420	.304	.927	.000	.000
	N	180	180	180	180	180	180	180
Relationships / conflicts with other professionals	Pearson Correlation	-.030	-.053	.059	.030	.032	.332**	.320**
	Sig. (2-tailed)	.688	.481	.434	.685	.668	.000	.000
	N	180	180	180	180	180	180	180
Lack of resources	Pearson Correlation	.054	.055	.069	-.118	.042	.335**	.261**
	Sig. (2-tailed)	.473	.463	.356	.115	.577	.000	.000
	N	180	180	180	180	180	180	180
Professional self doubt	Pearson Correlation	-.244**	-.210**	-.133	-.082	-.014	.253**	.354**
	Sig. (2-tailed)	.001	.005	.075	.271	.849	.001	.000
	N	180	180	180	180	180	180	180
Home-work conflict	Pearson Correlation	.109	.111	.323**	-.048	.253**	.358**	.282**
	Sig. (2-tailed)	.146	.137	.000	.519	.001	.000	.000
	N	180	180	180	180	180	180	180
mhpss total	Pearson Correlation	-.002	-.015	.128	-.098	.107	.580**	.527**
	Sig. (2-tailed)	.976	.840	.088	.191	.152	.000	.000
	N	180	180	180	180	180	180	180
saverage actual emotional support	Pearson Correlation	-.138	-.109	.013	-.008	-.024	.051	.096
	Sig. (2-tailed)	.065	.147	.858	.917	.750	.493	.202
	N	180	180	180	180	180	180	180
saverage actual practical support	Pearson Correlation	-.189*	-.133	.046	.015	-.072	-.199**	-.119
	Sig. (2-tailed)	.011	.076	.544	.846	.333	.007	.110
	N	180	180	180	180	180	180	180
saverage ideal emotional support	Pearson Correlation	-.206**	-.224**	-.019	.069	.078	.054	.106
	Sig. (2-tailed)	.005	.002	.795	.357	.296	.472	.155
	N	180	180	180	180	180	180	180
saverage ideal practical support	Pearson Correlation	-.197**	-.156*	.026	.037	-.060	-.048	.071
	Sig. (2-tailed)	.008	.036	.726	.619	.422	.519	.342
	N	180	180	180	180	180	180	180
saverage emotional support discrepancy	Pearson Correlation	-.026	-.087	-.040	.085	.118	-.015	-.021
	Sig. (2-tailed)	.725	.246	.594	.255	.114	.842	.776
	N	180	180	180	180	180	180	180

Correlations

		age in years	years of practice	work hpw	cpd hpm	therapy hpm	stress likert	impairment likert
saverage practical support discrepancy	Pearson Correlation	.040	.007	-.034	.023	.033	.227**	.253**
	Sig. (2-tailed)	.592	.924	.648	.763	.659	.002	.001
	N	180	180	180	180	180	180	180
paverage actual emotional support	Pearson Correlation	-.180*	-.185*	.123	.054	.083	-.045	.046
	Sig. (2-tailed)	.015	.013	.099	.472	.271	.547	.539
	N	180	180	180	180	180	180	180
paverage actual practical support	Pearson Correlation	-.181*	-.205**	.133	.119	-.040	-.080	.027
	Sig. (2-tailed)	.015	.006	.075	.112	.593	.285	.716
	N	180	180	180	180	180	180	180
paverage ideal emotional support	Pearson Correlation	-.232**	-.262**	.121	.036	.030	.088	.140
	Sig. (2-tailed)	.002	.000	.104	.628	.691	.242	.062
	N	180	180	180	180	180	180	180
paverage ideal practical support	Pearson Correlation	-.267**	-.297**	.141	.069	-.099	.080	.139
	Sig. (2-tailed)	.000	.000	.059	.356	.186	.283	.062
	N	180	180	180	180	180	180	180
paverage emotional support discrepancy	Pearson Correlation	-.083	-.123	-.001	-.027	-.081	.206**	.146
	Sig. (2-tailed)	.270	.099	.989	.724	.281	.006	.051
	N	180	180	180	180	180	180	180
paverage practical support discrepancy	Pearson Correlation	-.121	-.128	.009	-.076	-.085	.237**	.163*
	Sig. (2-tailed)	.107	.086	.909	.310	.256	.001	.029
	N	180	180	180	180	180	180	180
woc emotion focused	Pearson Correlation	-.029	.014	-.143	-.072	.152*	.132	.212**
	Sig. (2-tailed)	.698	.848	.056	.336	.042	.077	.004
	N	180	180	180	180	180	180	180
woc problem focused	Pearson Correlation	.201**	.172*	.041	-.139	-.002	.151*	.119
	Sig. (2-tailed)	.007	.021	.587	.062	.977	.043	.111
	N	180	180	180	180	180	180	180
ghqghqtotal	Pearson Correlation	.000	-.019	.074	.049	.165*	.524**	.524**
	Sig. (2-tailed)	.996	.798	.320	.517	.027	.000	.000
	N	180	180	180	180	180	180	180
ghqsomatic	Pearson Correlation	-.030	-.053	.092	-.059	.066	.427**	.358**
	Sig. (2-tailed)	.691	.477	.221	.429	.378	.000	.000
	N	180	180	180	180	180	180	180

Correlations

		age in years	years of practice	work hpw	cpd hpm	therapy hpm	stress likert	impairment likert
ghqanxiety	Pearson Correlation	.045	.003	.044	.097	.083	.564**	.536**
	Sig. (2-tailed)	.550	.965	.554	.193	.267	.000	.000
	N	180	180	180	180	180	180	180
ghqsocdys	Pearson Correlation	.028	.015	.088	.023	.098	.385**	.403**
	Sig. (2-tailed)	.712	.837	.242	.756	.190	.000	.000
	N	180	180	180	180	180	180	180
ghqdepression	Pearson Correlation	.040	.055	.071	.123	.305**	.244**	.299**
	Sig. (2-tailed)	.594	.463	.342	.099	.000	.001	.000
	N	180	180	180	180	180	180	180
ghq transformed	Pearson Correlation	.028	.001	.102	.033	.138	.553**	.524**
	Sig. (2-tailed)	.707	.991	.175	.658	.065	.000	.000
	N	180	180	180	180	180	180	180
letot transformed	Pearson Correlation	-.061	-.069	-.079	-.013	.096	.170*	.198**
	Sig. (2-tailed)	.416	.358	.295	.859	.201	.022	.008
	N	180	180	180	180	180	180	180
supervision transformed	Pearson Correlation	-.171*	-.121	-.061	.036	.129	-.075	-.098
	Sig. (2-tailed)	.022	.106	.419	.629	.084	.318	.189
	N	180	180	180	180	180	180	180
supervising transformed	Pearson Correlation	.060	.061	.188*	.084	-.015	.030	-.021
	Sig. (2-tailed)	.424	.416	.012	.264	.840	.685	.775
	N	180	180	180	180	180	180	180

Correlations

		ss total network	ps total network	Workload	Client-related difficulties	Organisational structure	Relationships / conflicts with other professionals	Lack of resources
age in years	Pearson Correlation	-.051	-.052	.058	-.203**	.127	-.030	.054
	Sig. (2-tailed)	.499	.490	.436	.006	.090	.688	.473
	N	180	180	180	180	180	180	180
years of practice	Pearson Correlation	-.097	-.069	.024	-.145	.079	-.053	.055
	Sig. (2-tailed)	.197	.358	.748	.053	.293	.481	.463
	N	180	180	180	180	180	180	180
work hpw	Pearson Correlation	-.084	.063	.234**	-.087	.060	.059	.069
	Sig. (2-tailed)	.262	.398	.002	.244	.420	.434	.356
	N	180	180	180	180	180	180	180
cpd hpm	Pearson Correlation	.007	.090	-.101	-.012	-.077	.030	-.118
	Sig. (2-tailed)	.925	.227	.176	.870	.304	.685	.115
	N	180	180	180	180	180	180	180
therapy hpm	Pearson Correlation	-.078	-.038	.094	.163*	-.007	.032	.042
	Sig. (2-tailed)	.298	.609	.209	.028	.927	.668	.577
	N	180	180	180	180	180	180	180
stress likert	Pearson Correlation	.007	.148*	.528**	.225**	.437**	.332**	.335**
	Sig. (2-tailed)	.930	.048	.000	.002	.000	.000	.000
	N	180	180	180	180	180	180	180
impairment likert	Pearson Correlation	.064	.232**	.401**	.295**	.386**	.320**	.261**
	Sig. (2-tailed)	.396	.002	.000	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
ss total network	Pearson Correlation	1.000	.505**	.021	.088	.080	.141	.085
	Sig. (2-tailed)	.	.000	.782	.242	.288	.059	.259
	N	180	180	180	180	180	180	180
ps total network	Pearson Correlation	.505**	1.000	.129	.271**	.146	.230**	.084
	Sig. (2-tailed)	.000	.	.084	.000	.051	.002	.260
	N	180	180	180	180	180	180	180
Workload	Pearson Correlation	.021	.129	1.000	.286**	.334**	.289**	.403**
	Sig. (2-tailed)	.782	.084	.	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
Client-related difficulties	Pearson Correlation	.088	.271**	.286**	1.000	.125	.286**	.202**
	Sig. (2-tailed)	.242	.000	.000	.	.095	.000	.007
	N	180	180	180	180	180	180	180

Correlations

		ss total network	ps total network	Workload	Client-related difficulties	Organisational structure	Relationships / conflicts with other professionals	Lack of resources
Organisational structure	Pearson Correlation	.080	.146	.334**	.125	1.000	.518**	.505**
	Sig. (2-tailed)	.288	.051	.000	.095	.	.000	.000
	N	180	180	180	180	180	180	180
Relationships / conflicts with other professionals	Pearson Correlation	.141	.230**	.289**	.286**	.518**	1.000	.358**
	Sig. (2-tailed)	.059	.002	.000	.000	.000	.	.000
	N	180	180	180	180	180	180	180
Lack of resources	Pearson Correlation	.085	.084	.403**	.202**	.505**	.358**	1.000
	Sig. (2-tailed)	.259	.260	.000	.007	.000	.000	.
	N	180	180	180	180	180	180	180
Professional self doubt	Pearson Correlation	.149*	.195**	.162*	.618**	.057	.199**	.161*
	Sig. (2-tailed)	.046	.009	.030	.000	.449	.007	.031
	N	180	180	180	180	180	180	180
Home-work conflict	Pearson Correlation	-.017	-.040	.612**	.205**	.241**	.215**	.313**
	Sig. (2-tailed)	.821	.595	.000	.006	.001	.004	.000
	N	180	180	180	180	180	180	180
mhpss total	Pearson Correlation	.122	.227**	.720**	.545**	.702**	.669**	.688**
	Sig. (2-tailed)	.102	.002	.000	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
saverage actual emotional support	Pearson Correlation	.088	.084	-.021	-.004	-.011	.018	-.149*
	Sig. (2-tailed)	.240	.264	.775	.958	.887	.814	.046
	N	180	180	180	180	180	180	180
saverage actual practical support	Pearson Correlation	.033	.001	-.150*	-.178*	-.124	-.125	-.193**
	Sig. (2-tailed)	.660	.992	.044	.017	.096	.095	.010
	N	180	180	180	180	180	180	180
saverage ideal emotional support	Pearson Correlation	.010	.102	.008	.106	.006	.106	-.125
	Sig. (2-tailed)	.899	.173	.916	.156	.938	.157	.094
	N	180	180	180	180	180	180	180
saverage ideal practical support	Pearson Correlation	.023	.082	-.043	-.014	.009	.065	-.125
	Sig. (2-tailed)	.757	.272	.567	.847	.908	.388	.094
	N	180	180	180	180	180	180	180
saverage emotional support discrepancy	Pearson Correlation	-.115	-.009	.039	.120	.021	.089	.076
	Sig. (2-tailed)	.125	.904	.604	.109	.775	.236	.308
	N	180	180	180	180	180	180	180

Correlations

		ss total network	ps total network	Workload	Client-related difficulties	Organisational structure	Relationships / conflicts with other professionals	Lack of resources
saverage practical support discrepancy	Pearson Correlation	-.020	.095	.164*	.237**	.187*	.253**	.128
	Sig. (2-tailed)	.791	.207	.028	.001	.012	.001	.086
	N	180	180	180	180	180	180	180
paverage actual emotional support	Pearson Correlation	.083	.184*	.047	.018	-.169*	-.083	-.166*
	Sig. (2-tailed)	.271	.013	.532	.813	.023	.269	.026
	N	180	180	180	180	180	180	180
paverage actual practical support	Pearson Correlation	.120	.198**	-.035	-.049	-.217**	-.076	-.294**
	Sig. (2-tailed)	.109	.008	.640	.514	.003	.310	.000
	N	180	180	180	180	180	180	180
paverage ideal emotional support	Pearson Correlation	.130	.265**	.107	.090	.046	.176*	-.022
	Sig. (2-tailed)	.081	.000	.151	.232	.537	.018	.771
	N	180	180	180	180	180	180	180
paverage ideal practical support	Pearson Correlation	.160*	.245**	.048	.034	.004	.170*	-.086
	Sig. (2-tailed)	.032	.001	.523	.651	.956	.023	.252
	N	180	180	180	180	180	180	180
paverage emotional support discrepancy	Pearson Correlation	.075	.128	.095	.112	.333**	.401**	.222**
	Sig. (2-tailed)	.314	.086	.206	.135	.000	.000	.003
	N	180	180	180	180	180	180	180
paverage practical support discrepancy	Pearson Correlation	.056	.064	.123	.123	.329**	.362**	.313**
	Sig. (2-tailed)	.458	.397	.101	.101	.000	.000	.000
	N	180	180	180	180	180	180	180
woc emotion focused	Pearson Correlation	.048	.045	.117	.228**	.227**	.362**	.260**
	Sig. (2-tailed)	.524	.550	.117	.002	.002	.000	.000
	N	180	180	180	180	180	180	180
woc problem focused	Pearson Correlation	.046	.064	.138	-.026	.192**	.160*	.071
	Sig. (2-tailed)	.537	.393	.065	.724	.010	.032	.343
	N	180	180	180	180	180	180	180
ghqghqtotal	Pearson Correlation	-.070	.051	.301**	.199**	.302**	.179*	.241**
	Sig. (2-tailed)	.350	.499	.000	.008	.000	.016	.001
	N	180	180	180	180	180	180	180
ghqsomatic	Pearson Correlation	-.023	.067	.293**	.197**	.280**	.143	.190*
	Sig. (2-tailed)	.762	.374	.000	.008	.000	.056	.011
	N	180	180	180	180	180	180	180

Correlations

		ss total network	ps total network	Workload	Client-related difficulties	Organisational structure	Relationships / conflicts with other professionals	Lack of resources
ghqanxiety	Pearson Correlation	-.058	.049	.334**	.202**	.320**	.218**	.262**
	Sig. (2-tailed)	.442	.512	.000	.007	.000	.003	.000
	N	180	180	180	180	180	180	180
ghqsocdys	Pearson Correlation	-.119	.026	.134	.011	.169*	-.032	.098
	Sig. (2-tailed)	.111	.731	.072	.885	.023	.674	.189
	N	180	180	180	180	180	180	180
ghqdepression	Pearson Correlation	-.062	.014	.157*	.164*	.181*	.130	.156*
	Sig. (2-tailed)	.406	.853	.035	.028	.015	.082	.036
	N	180	180	180	180	180	180	180
ghq transformed	Pearson Correlation	-.054	.070	.309**	.181*	.316**	.171*	.247**
	Sig. (2-tailed)	.469	.353	.000	.015	.000	.022	.001
	N	180	180	180	180	180	180	180
letot transformed	Pearson Correlation	.118	.214**	.023	.248**	.154*	.285**	.111
	Sig. (2-tailed)	.116	.004	.755	.001	.039	.000	.137
	N	180	180	180	180	180	180	180
supervision transformed	Pearson Correlation	-.061	.143	-.050	.092	-.223**	-.062	-.188*
	Sig. (2-tailed)	.416	.055	.501	.219	.003	.410	.011
	N	180	180	180	180	180	180	180
supervising transformed	Pearson Correlation	-.030	.092	.213**	.128	.107	.196**	.040
	Sig. (2-tailed)	.686	.218	.004	.087	.152	.008	.590
	N	180	180	180	180	180	180	180

Correlations

		Professional self doubt	Home-work conflict	mhpss total	saverage actual emotional support	saverage actual practical support	saverage ideal emotional support	saverage ideal practical support
age in years	Pearson Correlation	-.244**	.109	-.002	-.138	-.189*	-.206**	-.197**
	Sig. (2-tailed)	.001	.146	.976	.065	.011	.005	.008
	N	180	180	180	180	180	180	180
years of practice	Pearson Correlation	-.210**	.111	-.015	-.109	-.133	-.224**	-.156*
	Sig. (2-tailed)	.005	.137	.840	.147	.076	.002	.036
	N	180	180	180	180	180	180	180
work hpw	Pearson Correlation	-.133	.323**	.128	.013	.046	-.019	.026
	Sig. (2-tailed)	.075	.000	.088	.858	.544	.795	.726
	N	180	180	180	180	180	180	180
cpd hpm	Pearson Correlation	-.082	-.048	-.098	-.008	.015	.069	.037
	Sig. (2-tailed)	.271	.519	.191	.917	.846	.357	.619
	N	180	180	180	180	180	180	180
therapy hpm	Pearson Correlation	-.014	.253**	.107	-.024	-.072	.078	-.060
	Sig. (2-tailed)	.849	.001	.152	.750	.333	.296	.422
	N	180	180	180	180	180	180	180
stress likert	Pearson Correlation	.253**	.358**	.580**	.051	-.199**	.054	-.048
	Sig. (2-tailed)	.001	.000	.000	.493	.007	.472	.519
	N	180	180	180	180	180	180	180
impairment likert	Pearson Correlation	.354**	.282**	.527**	.096	-.119	.106	.071
	Sig. (2-tailed)	.000	.000	.000	.202	.110	.155	.342
	N	180	180	180	180	180	180	180
ss total network	Pearson Correlation	.149*	-.017	.122	.088	.033	.010	.023
	Sig. (2-tailed)	.046	.821	.102	.240	.660	.899	.757
	N	180	180	180	180	180	180	180
ps total network	Pearson Correlation	.195**	-.040	.227**	.084	.001	.102	.082
	Sig. (2-tailed)	.009	.595	.002	.264	.992	.173	.272
	N	180	180	180	180	180	180	180
Workload	Pearson Correlation	.162*	.612**	.720**	-.021	-.150*	.008	-.043
	Sig. (2-tailed)	.030	.000	.000	.775	.044	.916	.567
	N	180	180	180	180	180	180	180
Client-related difficulties	Pearson Correlation	.618**	.205**	.545**	-.004	-.178*	.106	-.014
	Sig. (2-tailed)	.000	.006	.000	.958	.017	.156	.847
	N	180	180	180	180	180	180	180

Correlations

		Professional self doubt	Home-work conflict	mhpss total	saverage actual emotional support	saverage actual practical support	saverage ideal emotional support	saverage ideal practical support
Organisational structure	Pearson Correlation	.057	.241**	.702**	-.011	-.124	.006	.009
	Sig. (2-tailed)	.449	.001	.000	.887	.096	.938	.908
	N	180	180	180	180	180	180	180
Relationships / conflicts with other professionals	Pearson Correlation	.199**	.215**	.669**	.018	-.125	.106	.065
	Sig. (2-tailed)	.007	.004	.000	.814	.095	.157	.388
	N	180	180	180	180	180	180	180
Lack of resources	Pearson Correlation	.161*	.313**	.688**	-.149*	-.193**	-.125	-.125
	Sig. (2-tailed)	.031	.000	.000	.046	.010	.094	.094
	N	180	180	180	180	180	180	180
Professional self doubt	Pearson Correlation	1.000	.082	.457**	-.044	-.116	.081	.005
	Sig. (2-tailed)	.	.273	.000	.560	.121	.281	.943
	N	180	180	180	180	180	180	180
Home-work conflict	Pearson Correlation	.082	1.000	.584**	-.141	-.198**	-.071	-.020
	Sig. (2-tailed)	.273	.	.000	.059	.008	.342	.793
	N	180	180	180	180	180	180	180
mhpss total	Pearson Correlation	.457**	.584**	1.000	-.072	-.237**	.021	-.027
	Sig. (2-tailed)	.000	.000	.	.338	.001	.776	.721
	N	180	180	180	180	180	180	180
saverage actual emotional support	Pearson Correlation	-.044	-.141	-.072	1.000	.614**	.711**	.553**
	Sig. (2-tailed)	.560	.059	.338	.	.000	.000	.000
	N	180	180	180	180	180	180	180
saverage actual practical support	Pearson Correlation	-.116	-.198**	-.237**	.614**	1.000	.441**	.718**
	Sig. (2-tailed)	.121	.008	.001	.000	.	.000	.000
	N	180	180	180	180	180	180	180
saverage ideal emotional support	Pearson Correlation	.081	-.071	.021	.711**	.441**	1.000	.702**
	Sig. (2-tailed)	.281	.342	.776	.000	.000	.	.000
	N	180	180	180	180	180	180	180
saverage ideal practical support	Pearson Correlation	.005	-.020	-.027	.553**	.718**	.702**	1.000
	Sig. (2-tailed)	.943	.793	.721	.000	.000	.000	.
	N	180	180	180	180	180	180	180
saverage emotional support discrepancy	Pearson Correlation	.149*	.124	.125	-.655**	-.396**	.066	-.030
	Sig. (2-tailed)	.046	.098	.095	.000	.000	.375	.687
	N	180	180	180	180	180	180	180

Correlations

		Professional self doubt	Home-work conflict	mhpss total	saverage actual emotional support	saverage actual practical support	saverage ideal emotional support	saverage ideal practical support
saverage practical support discrepancy	Pearson Correlation	.171*	.259**	.306**	-.231**	-.588**	.187*	.140
	Sig. (2-tailed)	.021	.000	.000	.002	.000	.012	.060
	N	180	180	180	180	180	180	180
paverage actual emotional support	Pearson Correlation	-.049	.039	-.095	.334**	.314**	.317**	.286**
	Sig. (2-tailed)	.516	.603	.206	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
paverage actual practical support	Pearson Correlation	-.045	-.033	-.181*	.377**	.448**	.358**	.407**
	Sig. (2-tailed)	.547	.659	.015	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
paverage ideal emotional support	Pearson Correlation	.044	.018	.106	.247**	.174*	.405**	.315**
	Sig. (2-tailed)	.555	.811	.158	.001	.020	.000	.000
	N	180	180	180	180	180	180	180
paverage ideal practical support	Pearson Correlation	.045	-.018	.046	.265**	.282**	.414**	.447**
	Sig. (2-tailed)	.546	.810	.540	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
paverage emotional support discrepancy	Pearson Correlation	.144	-.032	.310**	-.131	-.213**	.143	.051
	Sig. (2-tailed)	.054	.668	.000	.081	.004	.056	.498
	N	180	180	180	180	180	180	180
paverage practical support discrepancy	Pearson Correlation	.134	.023	.337**	-.175*	-.255**	.072	.048
	Sig. (2-tailed)	.074	.760	.000	.019	.001	.339	.525
	N	180	180	180	180	180	180	180
woc emotion focused	Pearson Correlation	.193**	.163*	.345**	.104	-.003	.136	.087
	Sig. (2-tailed)	.009	.029	.000	.164	.965	.069	.246
	N	180	180	180	180	180	180	180
woc problem focused	Pearson Correlation	-.080	.100	.147*	.216**	.068	.139	.092
	Sig. (2-tailed)	.288	.180	.050	.004	.365	.062	.219
	N	180	180	180	180	180	180	180
ghqghqtotal	Pearson Correlation	.253**	.354**	.414**	-.073	-.198**	.019	.029
	Sig. (2-tailed)	.001	.000	.000	.331	.008	.802	.703
	N	180	180	180	180	180	180	180
ghqsomatic	Pearson Correlation	.217**	.293**	.368**	-.085	-.179*	-.014	.040
	Sig. (2-tailed)	.003	.000	.000	.259	.016	.853	.595
	N	180	180	180	180	180	180	180

Correlations

		Professional self doubt	Home-work conflict	mhpss total	saverage actual emotional support	saverage actual practical support	saverage ideal emotional support	saverage ideal practical support
ghqanxiety	Pearson Correlation	.252**	.343**	.441**	-.144	-.297**	-.021	-.065
	Sig. (2-tailed)	.001	.000	.000	.054	.000	.783	.384
	N	180	180	180	180	180	180	180
ghqsocdys	Pearson Correlation	.138	.162*	.161*	.013	-.042	.017	.070
	Sig. (2-tailed)	.065	.029	.031	.866	.572	.825	.352
	N	180	180	180	180	180	180	180
ghqdepression	Pearson Correlation	.267**	.382**	.309**	-.174*	-.148*	-.112	-.061
	Sig. (2-tailed)	.000	.000	.000	.020	.047	.136	.419
	N	180	180	180	180	180	180	180
ghq transformed	Pearson Correlation	.280**	.373**	.426**	-.140	-.250**	-.047	-.019
	Sig. (2-tailed)	.000	.000	.000	.060	.001	.533	.797
	N	180	180	180	180	180	180	180
letot transformed	Pearson Correlation	.197**	.182*	.253**	-.129	-.186*	-.024	-.057
	Sig. (2-tailed)	.008	.015	.001	.084	.012	.750	.444
	N	180	180	180	180	180	180	180
supervision transformed	Pearson Correlation	.000	-.095	-.140	.158*	.040	.098	-.015
	Sig. (2-tailed)	.999	.206	.061	.034	.599	.191	.839
	N	180	180	180	180	180	180	180
supervising transformed	Pearson Correlation	-.071	.061	.163*	-.055	-.083	-.020	.025
	Sig. (2-tailed)	.343	.413	.029	.461	.271	.791	.743
	N	180	180	180	180	180	180	180

Correlations

		saverage emotional support discrepancy	saverage practical support discrepancy	paverage actual emotional support	paverage actual practical support	paverage ideal emotional support	paverage ideal practical support	paverage emotional support discrepancy
age in years	Pearson Correlation	-.026	.040	-.180*	-.181*	-.232**	-.267**	-.083
	Sig. (2-tailed)	.725	.592	.015	.015	.002	.000	.270
	N	180	180	180	180	180	180	180
years of practice	Pearson Correlation	-.087	.007	-.185*	-.205**	-.262**	-.297**	-.123
	Sig. (2-tailed)	.246	.924	.013	.006	.000	.000	.099
	N	180	180	180	180	180	180	180
work hpw	Pearson Correlation	-.040	-.034	.123	.133	.121	.141	-.001
	Sig. (2-tailed)	.594	.648	.099	.075	.104	.059	.989
	N	180	180	180	180	180	180	180
cpd hpm	Pearson Correlation	.085	.023	.054	.119	.036	.069	-.027
	Sig. (2-tailed)	.255	.763	.472	.112	.628	.356	.724
	N	180	180	180	180	180	180	180
therapy hpm	Pearson Correlation	.118	.033	.083	-.040	.030	-.099	-.081
	Sig. (2-tailed)	.114	.659	.271	.593	.691	.186	.281
	N	180	180	180	180	180	180	180
stress likert	Pearson Correlation	-.015	.227**	-.045	-.080	.088	.080	.206**
	Sig. (2-tailed)	.842	.002	.547	.285	.242	.283	.006
	N	180	180	180	180	180	180	180
impairment likert	Pearson Correlation	-.021	.253**	.046	.027	.140	.139	.146
	Sig. (2-tailed)	.776	.001	.539	.716	.062	.062	.051
	N	180	180	180	180	180	180	180
ss total network	Pearson Correlation	-.115	-.020	.083	.120	.130	.160*	.075
	Sig. (2-tailed)	.125	.791	.271	.109	.081	.032	.314
	N	180	180	180	180	180	180	180
ps total network	Pearson Correlation	-.009	.095	.184*	.198**	.265**	.245**	.128
	Sig. (2-tailed)	.904	.207	.013	.008	.000	.001	.086
	N	180	180	180	180	180	180	180
Workload	Pearson Correlation	.039	.164*	.047	-.035	.107	.048	.095
	Sig. (2-tailed)	.604	.028	.532	.640	.151	.523	.206
	N	180	180	180	180	180	180	180
Client-related difficulties	Pearson Correlation	.120	.237**	.018	-.049	.090	.034	.112
	Sig. (2-tailed)	.109	.001	.813	.514	.232	.651	.135
	N	180	180	180	180	180	180	180

Correlations

		saverage emotional support discrepancy	saverage practical support discrepancy	paverage actual emotional support	paverage actual practical support	paverage ideal emotional support	paverage ideal practical support	paverage emotional support discrepancy
Organisational structure	Pearson Correlation	.021	.187*	-.169*	-.217**	.046	.004	.333**
	Sig. (2-tailed)	.775	.012	.023	.003	.537	.956	.000
	N	180	180	180	180	180	180	180
Relationships / conflicts with other professionals	Pearson Correlation	.089	.253**	-.083	-.076	.176*	.170*	.401**
	Sig. (2-tailed)	.236	.001	.269	.310	.018	.023	.000
	N	180	180	180	180	180	180	180
Lack of resources	Pearson Correlation	.076	.128	-.166*	-.294**	-.022	-.086	.222**
	Sig. (2-tailed)	.308	.086	.026	.000	.771	.252	.003
	N	180	180	180	180	180	180	180
Professional self doubt	Pearson Correlation	.149*	.171*	-.049	-.045	.044	.045	.144
	Sig. (2-tailed)	.046	.021	.516	.547	.555	.546	.054
	N	180	180	180	180	180	180	180
Home-work conflict	Pearson Correlation	.124	.259**	.039	-.033	.018	-.018	-.032
	Sig. (2-tailed)	.098	.000	.603	.659	.811	.810	.668
	N	180	180	180	180	180	180	180
mhpss total	Pearson Correlation	.125	.306**	-.095	-.181*	.106	.046	.310**
	Sig. (2-tailed)	.095	.000	.206	.015	.158	.540	.000
	N	180	180	180	180	180	180	180
saverage actual emotional support	Pearson Correlation	-.655**	-.231**	.334**	.377**	.247**	.265**	-.131
	Sig. (2-tailed)	.000	.002	.000	.000	.001	.000	.081
	N	180	180	180	180	180	180	180
saverage actual practical support	Pearson Correlation	-.396**	-.588**	.314**	.448**	.174*	.282**	-.213**
	Sig. (2-tailed)	.000	.000	.000	.000	.020	.000	.004
	N	180	180	180	180	180	180	180
saverage ideal emotional support	Pearson Correlation	.066	.187*	.317**	.358**	.405**	.414**	.143
	Sig. (2-tailed)	.375	.012	.000	.000	.000	.000	.056
	N	180	180	180	180	180	180	180
saverage ideal practical support	Pearson Correlation	-.030	.140	.286**	.407**	.315**	.447**	.051
	Sig. (2-tailed)	.687	.060	.000	.000	.000	.000	.498
	N	180	180	180	180	180	180	180
saverage emotional support discrepancy	Pearson Correlation	1.000	.528**	-.134	-.150*	.085	.069	.339**
	Sig. (2-tailed)	.	.000	.073	.044	.256	.359	.000
	N	180	180	180	180	180	180	180

Correlations

		saverage emotional support discrepancy	saverage practical support discrepancy	paverage actual emotional support	paverage actual practical support	paverage ideal emotional support	paverage ideal practical support	paverage emotional support discrepancy
saverage practical support discrepancy	Pearson Correlation	.528**	1.000	-.115	-.164*	.119	.119	.362**
	Sig. (2-tailed)	.000	.	.124	.028	.111	.112	.000
	N	180	180	180	180	180	180	180
paverage actual emotional support	Pearson Correlation	-.134	-.115	1.000	.829**	.791**	.665**	-.310**
	Sig. (2-tailed)	.073	.124	.	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
paverage actual practical support	Pearson Correlation	-.150*	-.164*	.829**	1.000	.665**	.771**	-.243**
	Sig. (2-tailed)	.044	.028	.000	.	.000	.000	.001
	N	180	180	180	180	180	180	180
paverage ideal emotional support	Pearson Correlation	.085	.119	.791**	.665**	1.000	.850**	.337**
	Sig. (2-tailed)	.256	.111	.000	.000	.	.000	.000
	N	180	180	180	180	180	180	180
paverage ideal practical support	Pearson Correlation	.069	.119	.665**	.771**	.850**	1.000	.297**
	Sig. (2-tailed)	.359	.112	.000	.000	.000	.	.000
	N	180	180	180	180	180	180	180
paverage emotional support discrepancy	Pearson Correlation	.339**	.362**	-.310**	-.243**	.337**	.297**	1.000
	Sig. (2-tailed)	.000	.000	.000	.001	.000	.000	.
	N	180	180	180	180	180	180	180
paverage practical support discrepancy	Pearson Correlation	.324**	.418**	-.263**	-.363**	.252**	.314**	.796**
	Sig. (2-tailed)	.000	.000	.000	.000	.001	.000	.000
	N	180	180	180	180	180	180	180
woc emotion focused	Pearson Correlation	-.002	.106	.041	.044	.096	.081	.086
	Sig. (2-tailed)	.979	.158	.582	.557	.199	.279	.251
	N	180	180	180	180	180	180	180
woc problem focused	Pearson Correlation	-.157*	.010	.190*	.196**	.197**	.173*	.015
	Sig. (2-tailed)	.036	.891	.011	.009	.008	.020	.846
	N	180	180	180	180	180	180	180
ghqghqtotal	Pearson Correlation	.124	.316**	-.060	-.099	.015	-.014	.117
	Sig. (2-tailed)	.098	.000	.422	.188	.837	.847	.119
	N	180	180	180	180	180	180	180
ghqsomatic	Pearson Correlation	.105	.301**	-.140	-.161*	-.027	-.038	.174*
	Sig. (2-tailed)	.160	.000	.060	.031	.717	.611	.020
	N	180	180	180	180	180	180	180

Correlations

		saverage emotional support discrepancy	saverage practical support discrepancy	paverage actual emotional support	paverage actual practical support	paverage ideal emotional support	paverage ideal practical support	paverage emotional support discrepancy
ghqanxiety	Pearson Correlation	.182*	.346**	-.085	-.115	-.011	-.024	.114
	Sig. (2-tailed)	.014	.000	.258	.124	.887	.753	.128
	N	180	180	180	180	180	180	180
ghqsocdys	Pearson Correlation	.000	.141	.002	-.012	.032	.024	.046
	Sig. (2-tailed)	.999	.058	.977	.877	.671	.753	.538
	N	180	180	180	180	180	180	180
ghqdepression	Pearson Correlation	.127	.140	-.003	-.060	-.036	-.109	-.052
	Sig. (2-tailed)	.090	.060	.970	.426	.630	.144	.490
	N	180	180	180	180	180	180	180
ghq transformed	Pearson Correlation	.149*	.334**	-.135	-.156*	-.041	-.057	.144
	Sig. (2-tailed)	.046	.000	.071	.037	.586	.446	.054
	N	180	180	180	180	180	180	180
letot transformed	Pearson Correlation	.157*	.198**	-.110	-.044	-.027	.009	.127
	Sig. (2-tailed)	.035	.008	.142	.553	.718	.901	.089
	N	180	180	180	180	180	180	180
supervision transformed	Pearson Correlation	-.118	-.074	.178*	.210**	.159*	.143	-.026
	Sig. (2-tailed)	.113	.324	.017	.005	.032	.055	.729
	N	180	180	180	180	180	180	180
supervising transformed	Pearson Correlation	.057	.146	-.188*	-.137	-.082	-.006	.163*
	Sig. (2-tailed)	.447	.051	.011	.066	.274	.940	.029
	N	180	180	180	180	180	180	180

Correlations

		paverage practical support discrepancy	woc emotion focused	woc problem focused	ghqghqtotal	ghqsomatic	ghqanxiety	ghqsocdys
age in years	Pearson Correlation	-.121	-.029	.201**	.000	-.030	.045	.028
	Sig. (2-tailed)	.107	.698	.007	.996	.691	.550	.712
	N	180	180	180	180	180	180	180
years of practice	Pearson Correlation	-.128	.014	.172*	-.019	-.053	.003	.015
	Sig. (2-tailed)	.086	.848	.021	.798	.477	.965	.837
	N	180	180	180	180	180	180	180
work hpw	Pearson Correlation	.009	-.143	.041	.074	.092	.044	.088
	Sig. (2-tailed)	.909	.056	.587	.320	.221	.554	.242
	N	180	180	180	180	180	180	180
cpd hpm	Pearson Correlation	-.076	-.072	-.139	.049	-.059	.097	.023
	Sig. (2-tailed)	.310	.336	.062	.517	.429	.193	.756
	N	180	180	180	180	180	180	180
therapy hpm	Pearson Correlation	-.085	.152*	-.002	.165*	.066	.083	.098
	Sig. (2-tailed)	.256	.042	.977	.027	.378	.267	.190
	N	180	180	180	180	180	180	180
stress likert	Pearson Correlation	.237**	.132	.151*	.524**	.427**	.564**	.385**
	Sig. (2-tailed)	.001	.077	.043	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
impairment likert	Pearson Correlation	.163*	.212**	.119	.524**	.358**	.536**	.403**
	Sig. (2-tailed)	.029	.004	.111	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
ss total network	Pearson Correlation	.056	.048	.046	-.070	-.023	-.058	-.119
	Sig. (2-tailed)	.458	.524	.537	.350	.762	.442	.111
	N	180	180	180	180	180	180	180
ps total network	Pearson Correlation	.064	.045	.064	.051	.067	.049	.026
	Sig. (2-tailed)	.397	.550	.393	.499	.374	.512	.731
	N	180	180	180	180	180	180	180
Workload	Pearson Correlation	.123	.117	.138	.301**	.293**	.334**	.134
	Sig. (2-tailed)	.101	.117	.065	.000	.000	.000	.072
	N	180	180	180	180	180	180	180
Client-related difficulties	Pearson Correlation	.123	.228**	-.026	.199**	.197**	.202**	.011
	Sig. (2-tailed)	.101	.002	.724	.008	.008	.007	.885
	N	180	180	180	180	180	180	180

Correlations

		paverage practical support discrepancy	woc emotion focused	woc problem focused	ghqghqtotal	ghqsomatic	ghqanxiety	ghqsocdys
Organisational structure	Pearson Correlation	.329**	.227**	.192**	.302**	.280**	.320**	.169*
	Sig. (2-tailed)	.000	.002	.010	.000	.000	.000	.023
	N	180	180	180	180	180	180	180
Relationships / conflicts with other professionals	Pearson Correlation	.362**	.362**	.160*	.179*	.143	.218**	-.032
	Sig. (2-tailed)	.000	.000	.032	.016	.056	.003	.674
	N	180	180	180	180	180	180	180
Lack of resources	Pearson Correlation	.313**	.260**	.071	.241**	.190*	.262**	.098
	Sig. (2-tailed)	.000	.000	.343	.001	.011	.000	.189
	N	180	180	180	180	180	180	180
Professional self doubt	Pearson Correlation	.134	.193**	-.080	.253**	.217**	.252**	.138
	Sig. (2-tailed)	.074	.009	.288	.001	.003	.001	.065
	N	180	180	180	180	180	180	180
Home-work conflict	Pearson Correlation	.023	.163*	.100	.354**	.293**	.343**	.162*
	Sig. (2-tailed)	.760	.029	.180	.000	.000	.000	.029
	N	180	180	180	180	180	180	180
mhpss total	Pearson Correlation	.337**	.345**	.147*	.414**	.368**	.441**	.161*
	Sig. (2-tailed)	.000	.000	.050	.000	.000	.000	.031
	N	180	180	180	180	180	180	180
saverage actual emotional support	Pearson Correlation	-.175*	.104	.216**	-.073	-.085	-.144	.013
	Sig. (2-tailed)	.019	.164	.004	.331	.259	.054	.866
	N	180	180	180	180	180	180	180
saverage actual practical support	Pearson Correlation	-.255**	-.003	.068	-.198**	-.179*	-.297**	-.042
	Sig. (2-tailed)	.001	.965	.365	.008	.016	.000	.572
	N	180	180	180	180	180	180	180
saverage ideal emotional support	Pearson Correlation	.072	.136	.139	.019	-.014	-.021	.017
	Sig. (2-tailed)	.339	.069	.062	.802	.853	.783	.825
	N	180	180	180	180	180	180	180
saverage ideal practical support	Pearson Correlation	.048	.087	.092	.029	.040	-.065	.070
	Sig. (2-tailed)	.525	.246	.219	.703	.595	.384	.352
	N	180	180	180	180	180	180	180
saverage emotional support discrepancy	Pearson Correlation	.324**	-.002	-.157*	.124	.105	.182*	.000
	Sig. (2-tailed)	.000	.979	.036	.098	.160	.014	.999
	N	180	180	180	180	180	180	180

Correlations

		paverage practical support discrepancy	woc emotion focused	woc problem focused	ghqghqtotal	ghqsomatic	ghqanxiety	ghqsocdys
saverage practical support discrepancy	Pearson Correlation	.418**	.106	.010	.316**	.301**	.346**	.141
	Sig. (2-tailed)	.000	.158	.891	.000	.000	.000	.058
	N	180	180	180	180	180	180	180
paverage actual emotional support	Pearson Correlation	-.263**	.041	.190*	-.060	-.140	-.085	.002
	Sig. (2-tailed)	.000	.582	.011	.422	.060	.258	.977
	N	180	180	180	180	180	180	180
paverage actual practical support	Pearson Correlation	-.363**	.044	.196**	-.099	-.161*	-.115	-.012
	Sig. (2-tailed)	.000	.557	.009	.188	.031	.124	.877
	N	180	180	180	180	180	180	180
paverage ideal emotional support	Pearson Correlation	.252**	.096	.197**	.015	-.027	-.011	.032
	Sig. (2-tailed)	.001	.199	.008	.837	.717	.887	.671
	N	180	180	180	180	180	180	180
paverage ideal practical support	Pearson Correlation	.314**	.081	.173*	-.014	-.038	-.024	.024
	Sig. (2-tailed)	.000	.279	.020	.847	.611	.753	.753
	N	180	180	180	180	180	180	180
paverage emotional support discrepancy	Pearson Correlation	.796**	.086	.015	.117	.174*	.114	.046
	Sig. (2-tailed)	.000	.251	.846	.119	.020	.128	.538
	N	180	180	180	180	180	180	180
paverage practical support discrepancy	Pearson Correlation	1.000	.053	-.038	.126	.184*	.137	.052
	Sig. (2-tailed)	.	.480	.609	.093	.013	.066	.488
	N	180	180	180	180	180	180	180
woc emotion focused	Pearson Correlation	.053	1.000	.290**	.255**	.129	.242**	.103
	Sig. (2-tailed)	.480	.	.000	.001	.085	.001	.168
	N	180	180	180	180	180	180	180
woc problem focused	Pearson Correlation	-.038	.290**	1.000	.069	.048	.132	-.034
	Sig. (2-tailed)	.609	.000	.	.356	.521	.078	.648
	N	180	180	180	180	180	180	180
ghqghqtotal	Pearson Correlation	.126	.255**	.069	1.000	.754**	.853**	.709**
	Sig. (2-tailed)	.093	.001	.356	.	.000	.000	.000
	N	180	180	180	180	180	180	180
ghqsomatic	Pearson Correlation	.184*	.129	.048	.754**	1.000	.627**	.405**
	Sig. (2-tailed)	.013	.085	.521	.000	.	.000	.000
	N	180	180	180	180	180	180	180

Correlations

		paverage practical support discrepancy	woc emotion focused	woc problem focused	ghqghqtotal	ghqsomatic	ghqanxiety	ghqsocdys
ghqanxiety	Pearson Correlation	.137	.242**	.132	.853**	.627**	1.000	.520**
	Sig. (2-tailed)	.066	.001	.078	.000	.000	.	.000
	N	180	180	180	180	180	180	180
ghqsocdys	Pearson Correlation	.052	.103	-.034	.709**	.405**	.520**	1.000
	Sig. (2-tailed)	.488	.168	.648	.000	.000	.000	.
	N	180	180	180	180	180	180	180
ghqdepression	Pearson Correlation	-.071	.256**	.019	.627**	.292**	.542**	.440**
	Sig. (2-tailed)	.344	.001	.800	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
ghq transformed	Pearson Correlation	.148*	.222**	.060	.898**	.818**	.879**	.683**
	Sig. (2-tailed)	.047	.003	.423	.000	.000	.000	.000
	N	180	180	180	180	180	180	180
letot transformed	Pearson Correlation	.080	.294**	.077	.284**	.190*	.330**	.051
	Sig. (2-tailed)	.286	.000	.301	.000	.011	.000	.495
	N	180	180	180	180	180	180	180
supervision transformed	Pearson Correlation	-.104	-.011	-.010	-.010	-.001	-.043	.049
	Sig. (2-tailed)	.166	.884	.891	.893	.988	.568	.513
	N	180	180	180	180	180	180	180
supervising transformed	Pearson Correlation	.196**	.083	-.025	.098	.151*	.132	.001
	Sig. (2-tailed)	.008	.265	.736	.189	.044	.078	.987
	N	180	180	180	180	180	180	180

Correlations

		ghqdepression	ghq transformed	letot transformed	supervision transformed	supervising transformed
age in years	Pearson Correlation	.040	.028	-.061	-.171*	.060
	Sig. (2-tailed)	.594	.707	.416	.022	.424
	N	180	180	180	180	180
years of practice	Pearson Correlation	.055	.001	-.069	-.121	.061
	Sig. (2-tailed)	.463	.991	.358	.106	.416
	N	180	180	180	180	180
work hpw	Pearson Correlation	.071	.102	-.079	-.061	.188*
	Sig. (2-tailed)	.342	.175	.295	.419	.012
	N	180	180	180	180	180
cpd hpm	Pearson Correlation	.123	.033	-.013	.036	.084
	Sig. (2-tailed)	.099	.658	.859	.629	.264
	N	180	180	180	180	180
therapy hpm	Pearson Correlation	.305**	.138	.096	.129	-.015
	Sig. (2-tailed)	.000	.065	.201	.084	.840
	N	180	180	180	180	180
stress likert	Pearson Correlation	.244**	.553**	.170*	-.075	.030
	Sig. (2-tailed)	.001	.000	.022	.318	.685
	N	180	180	180	180	180
impairment likert	Pearson Correlation	.299**	.524**	.198**	-.098	-.021
	Sig. (2-tailed)	.000	.000	.008	.189	.775
	N	180	180	180	180	180
ss total network	Pearson Correlation	-.062	-.054	.118	-.061	-.030
	Sig. (2-tailed)	.406	.469	.116	.416	.686
	N	180	180	180	180	180
ps total network	Pearson Correlation	.014	.070	.214**	.143	.092
	Sig. (2-tailed)	.853	.353	.004	.055	.218
	N	180	180	180	180	180
Workload	Pearson Correlation	.157*	.309**	.023	-.050	.213**
	Sig. (2-tailed)	.035	.000	.755	.501	.004
	N	180	180	180	180	180
Client-related difficulties	Pearson Correlation	.164*	.181*	.248**	.092	.128
	Sig. (2-tailed)	.028	.015	.001	.219	.087
	N	180	180	180	180	180

Correlations

		ghqdepression	ghq transformed	letot transformed	supervision transformed	supervising transformed
Organisational structure	Pearson Correlation	.181*	.316**	.154*	-.223**	.107
	Sig. (2-tailed)	.015	.000	.039	.003	.152
	N	180	180	180	180	180
Relationships / conflicts with other professionals	Pearson Correlation	.130	.171*	.285**	-.062	.196**
	Sig. (2-tailed)	.082	.022	.000	.410	.008
	N	180	180	180	180	180
Lack of resources	Pearson Correlation	.156*	.247**	.111	-.188*	.040
	Sig. (2-tailed)	.036	.001	.137	.011	.590
	N	180	180	180	180	180
Professional self doubt	Pearson Correlation	.267**	.280**	.197**	.000	-.071
	Sig. (2-tailed)	.000	.000	.008	.999	.343
	N	180	180	180	180	180
Home-work conflict	Pearson Correlation	.382**	.373**	.182*	-.095	.061
	Sig. (2-tailed)	.000	.000	.015	.206	.413
	N	180	180	180	180	180
mhpss total	Pearson Correlation	.309**	.426**	.253**	-.140	.163*
	Sig. (2-tailed)	.000	.000	.001	.061	.029
	N	180	180	180	180	180
saverage actual emotional support	Pearson Correlation	-.174*	-.140	-.129	.158*	-.055
	Sig. (2-tailed)	.020	.060	.084	.034	.461
	N	180	180	180	180	180
saverage actual practical support	Pearson Correlation	-.148*	-.250**	-.186*	.040	-.083
	Sig. (2-tailed)	.047	.001	.012	.599	.271
	N	180	180	180	180	180
saverage ideal emotional support	Pearson Correlation	-.112	-.047	-.024	.098	-.020
	Sig. (2-tailed)	.136	.533	.750	.191	.791
	N	180	180	180	180	180
saverage ideal practical support	Pearson Correlation	-.061	-.019	-.057	-.015	.025
	Sig. (2-tailed)	.419	.797	.444	.839	.743
	N	180	180	180	180	180
saverage emotional support discrepancy	Pearson Correlation	.127	.149*	.157*	-.118	.057
	Sig. (2-tailed)	.090	.046	.035	.113	.447
	N	180	180	180	180	180

Correlations

		ghqdepression	ghq transformed	letot transformed	supervision transformed	supervising transformed
saverage practical support discrepancy	Pearson Correlation	.140	.334**	.198**	-.074	.146
	Sig. (2-tailed)	.060	.000	.008	.324	.051
	N	180	180	180	180	180
paverage actual emotional support	Pearson Correlation	-.003	-.135	-.110	.178*	-.188*
	Sig. (2-tailed)	.970	.071	.142	.017	.011
	N	180	180	180	180	180
paverage actual practical support	Pearson Correlation	-.060	-.156*	-.044	.210**	-.137
	Sig. (2-tailed)	.426	.037	.553	.005	.066
	N	180	180	180	180	180
paverage ideal emotional support	Pearson Correlation	-.036	-.041	-.027	.159*	-.082
	Sig. (2-tailed)	.630	.586	.718	.032	.274
	N	180	180	180	180	180
paverage ideal practical support	Pearson Correlation	-.109	-.057	.009	.143	-.006
	Sig. (2-tailed)	.144	.446	.901	.055	.940
	N	180	180	180	180	180
paverage emotional support discrepancy	Pearson Correlation	-.052	.144	.127	-.026	.163*
	Sig. (2-tailed)	.490	.054	.089	.729	.029
	N	180	180	180	180	180
paverage practical support discrepancy	Pearson Correlation	-.071	.148*	.080	-.104	.196**
	Sig. (2-tailed)	.344	.047	.286	.166	.008
	N	180	180	180	180	180
woc emotion focused	Pearson Correlation	.256**	.222**	.294**	-.011	.083
	Sig. (2-tailed)	.001	.003	.000	.884	.265
	N	180	180	180	180	180
woc problem focused	Pearson Correlation	.019	.060	.077	-.010	-.025
	Sig. (2-tailed)	.800	.423	.301	.891	.736
	N	180	180	180	180	180
ghqghqtotal	Pearson Correlation	.627**	.898**	.284**	-.010	.098
	Sig. (2-tailed)	.000	.000	.000	.893	.189
	N	180	180	180	180	180
ghqsomatic	Pearson Correlation	.292**	.818**	.190*	-.001	.151*
	Sig. (2-tailed)	.000	.000	.011	.988	.044
	N	180	180	180	180	180

Correlations

		ghqdepression	ghq transformed	letot transformed	supervision transformed	supervising transformed
ghqanxiety	Pearson Correlation	.542**	.879**	.330**	-.043	.132
	Sig. (2-tailed)	.000	.000	.000	.568	.078
	N	180	180	180	180	180
ghqsocdys	Pearson Correlation	.440**	.683**	.051	.049	.001
	Sig. (2-tailed)	.000	.000	.495	.513	.987
	N	180	180	180	180	180
ghqdepression	Pearson Correlation	1.000	.594**	.302**	-.077	.011
	Sig. (2-tailed)	.	.000	.000	.306	.883
	N	180	180	180	180	180
ghq transformed	Pearson Correlation	.594**	1.000	.301**	-.011	.134
	Sig. (2-tailed)	.000	.	.000	.880	.073
	N	180	180	180	180	180
letot transformed	Pearson Correlation	.302**	.301**	1.000	-.006	.006
	Sig. (2-tailed)	.000	.000	.	.940	.932
	N	180	180	180	180	180
supervision transformed	Pearson Correlation	-.077	-.011	-.006	1.000	-.040
	Sig. (2-tailed)	.306	.880	.940	.	.594
	N	180	180	180	180	180
supervising transformed	Pearson Correlation	.011	.134	.006	-.040	1.000
	Sig. (2-tailed)	.883	.073	.932	.594	.
	N	180	180	180	180	180

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Results of Buffering Effect Analyses (Univariate analysis of variance)

Life Events / Social Support

LES total / Perceived emotional support

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	3.429	3	1.143	6.189	0.001
Intercept	1568.843	1	1568.843	8495.061	0.000
LETOTMED	2.648	1	2.648	14.336	0.000
SSESMED	0.427	1	0.427	2.310	0.130
LETOTMED * SSESMED	0.001	1	0.001	0.058	0.809
Error	32.503	176	0.185		
Total	1634.287	180			
Corrected Total	35.932	179			

LES total / Perceived practical support

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	4.277	3	1.426	7.926	0.000
Intercept	1579.498	1	1579.498	8781.717	0.000
LETOTMED	2.539	1	2.539	14.117	0.000
SSPSMED	1.275	1	1.275	7.089	0.008
LETOTMED * SSPSMED	0.009	1	0.009	0.055	0.815
Error	31.656	176	0.180		
Total	1634.287	180			
Corrected Total	35.932	179			

LES total / Emotional support discrepancy

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	4.316	3	1.439	8.008	0.000
Intercept	1591.999	1	1591.999	8862.158	0.000
LETOTMED	2.677	1	2.677	14.902	0.000
SSESDMED	1.155	1	1.155	6.428	0.012
LETOTMED * SSESDMED	0.171	1	0.171	.950	0.331
Error	31.617	176	0.180		
Total	1634.287	180			
Corrected Total	35.932	179			

LES total / Practical support discrepancy

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	4.806	3	1.602	9.057	0.000
Intercept	1567.395	1	1567.395	8862.532	0.000
LETOTMED	2.299	1	2.299	12.999	0.000
SSPSDMED	1.799	1	1.799	10.174	0.002
LETOTMED * SSPSDMED	0.001	1	0.001	0.088	0.768
Error	31.127	176	0.177		
Total	1634.287	180			
Corrected Total	35.932	179			

Work Stressors / Professional Support

MHPSS total / Perceived emotional support

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	4.875	3	1.625	9.210	0.000
Intercept	1567.361	1	1567.361	8882.288	0.000
MHPSSMED	4.506	1	4.506	25.538	0.000
PSESMED	0.002	1	0.002	0.148	0.701
MHPSSMED * PSESMED	0.224	1	0.224	1.268	0.262
Error	31.057	176	0.176		
Total	1634.287	180			
Corrected Total	35.932	179			

MHPSS total / Perceived practical support

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	4.710	3	1.570	8.850	0.000
Intercept	1555.144	1	1555.144	8766.311	0.000
MHPSSMED	4.307	1	4.307	24.276	0.000
PSPSMED	0.007	1	0.007	0.430	0.513
MHPSSMED * PSPSMED	0.001	1	0.001	0.061	0.806
Error	31.222	176	0.177		
Total	1634.287	180			
Corrected Total	35.932	179			

MHPSS total / Emotional support discrepancy

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	5.190	3	1.730	9.904	0.000
Intercept	1580.869	1	1580.869	9050.510	0.000
MHPSSMED	4.375	1	4.375	25.049	0.000
PSESDMED	0.003	1	0.003	0.023	0.880
MHPSSMED * PSESDMED	0.564	1	0.564	3.231	0.074
Error	30.742	176	0.175		
Total	1634.287	180			
Corrected Total	35.932	179			

MHPSS total / Practical support discrepancy

Source	Type III Sum of Squares	df	Mean Square	F	Significance
Corrected Model	4.658	3	1.553	8.737	0.000
Intercept	1470.059	1	1470.059	8272.898	0.000
MHPSSMED	4.353	1	4.353	24.498	0.000
PSPSDMED	0.001	1	0.001	0.059	0.809
MHPSSMED * PSPSDMED	0.002	1	0.002	0.146	0.703
Error	31.274	176	0.178		
Total	1634.287	180			
Corrected Total	35.932	179			