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The role of relationship reciprocity and self-efficacy on well-being and burnout in clinical psychology trainees

Summary: This study aimed to extend knowledge of factors which may be linked with clinical psychology trainee resilience by exploring reciprocity in trainee relationships and self-efficacy beliefs and their associations with trainee burnout and well-being.

Introduction

Stressors for clinical psychology (CP) trainees in the U.K. have not diminished since Cushway (1992) reported her initial findings. Indeed, it could be argued that contextual changes have led to a proliferation of stressors; courses have developed more searching ways of assessing competence, the 'New Ways of Working' initiative has raised the expectation that clinical psychologists are able to supervise and lead as soon as they qualify (British Psychological Society, 2010), and sickness-absence policies place pressure on trainees not to succumb to illness.

Cushway's national survey in the 1990's found that 75% of 287 trainees reported being moderately/very stressed (Cushway, 1992). Since that time, most courses have taken steps to ensure that trainees have the opportunity to address some of the main stressors reported by Cushway's sample. However, in 2000 the Clearing House Project (Phillips, Hatton and Gray, 2004) found over 90% of a sample of 71 third year trainees

were still very stressed, suggesting a need to carry out further work to understand and manage sources of the problem.

Snyder and Lopez (2005) reviewed evidence on the factors and processes that contribute to positive personal outcomes in adverse life circumstances, concluding that having relationships which demonstrate responsiveness is a key contributing factor. Gilligan (2000) proposes responsive relationships as one of three prerequisites of resilience:

- Developing a sense of a secure base through typical daily and seasonal routines with responsive people
- Maximising self-esteem through secure harmonious relationships and achieving success in accomplishing tasks related to one's own interests
- Having a sense of agency

Relationships seem to play a large part in achieving resilience. A series of studies have examined the application of social exchange theory (see Schaufeli, 2006 for a review), to understand the morale of staff working in helping professions (e.g. Duffy, Oyebode & Allen, 2009; Thomas & Rose, 2010 Rose, Madurai, Thomas, Duffy and Oyebode (2010). These indicate that it is not so much the balance of reciprocity in relationships with clients that has an impact on staff morale, but the balance in relationships with colleagues and the employing organisation.

Self-efficacy, defined as *"The belief in one's capabilities to organise and execute courses of action required to produce given attainments"* (Bandura, 1997, p. 14) has received much attention in educational settings (e.g. Bandura, 1986; Zimmerman, 1989; Pajares, 1996; Chemers, Hu & Garcia, 2001) and may also play an important role in predicting the response to stress in trainees.   Individuals with high-self efficacy tend to believe that they can maintain high levels of job performance despite the presence of challenging job-related stressors, whereas individuals with low self-efficacy may believe that tasks are harder than they really are and thus find it difficult to problem solve creatively (Bandura, 1997; Zimmerman, 2000).

Aim

The present study aimed to extend knowledge of factors which may be linked with trainee resilience in the face of stress, by exploring reciprocity in trainee relationships and self-efficacy beliefs and their associations with trainee burnout and psychological well-being. In line with previous research, we hypothesised that:

a. Poorer perceived reciprocity (i.e. over-investment), in relationships is associated with and contributes to greater indications of burnout.

b. Reciprocity in relationships (i.e. no sense of over-investment), is related to higher psychological well-being.

c. Self-efficacy is associated with and contributes to greater psychological well-being and lower levels of burnout.

Method

Design

This was a cross-sectional questionnaire-based survey of UK CP trainees (year 2 to completion of training), which considered the relationship between self-efficacy and overall reciprocity on outcome variables of psychological well-being and burnout.

Procedure

Once ethical approval had been granted, the first stage of the study involved conducting two focus groups with trainees to adapt an existing questionnaire on reciprocity (van Horn, Schaufeli, and Enzmann, 1999; van Horn, Schaufeli, and Taris, 2001). The second stage employed a cross-sectional survey to administer a series of online questionnaires published on Lime Survey, an open source online survey application.

All Course Directors of UK clinical psychology doctorate programmes were approached by email. Course Administrators were then provided with a participant information leaflet and an email to circulate to the second, third and in some cases, fourth year trainees. These year groups were chosen as it was deemed necessary for trainees to have sufficient experience of clinical training to answer detailed questions about the experience. The email to trainees contained information about the study, a link to the online questionnaires and the timescale for completion (four weeks). All responses were anonymous, but participants were given the option to create a unique code to allow them to withdraw later if they wished.

Questionnaires

Demographic Information

Participants were asked to provide demographic information and identify the client/service user group they were working with at the time of the survey.

Reciprocity Questionnaire

The Reciprocity Questionnaire was adapted from the measure developed by van Horn et al. (2001) and later adapted by Jeffcott (2002), Duffy, Oyebode and Allen (2010), Rose et al., (2010) and Thomas and Rose (2010). It has good convergent validity with a global reciprocity measure (Thomas and Rose, 2010) and is used to assess investment *in* and outcomes *from* different exchange relationships. In order to establish the key relationships in the current context, two focus groups were conducted with trainees from one course to discuss questionnaire style, format and content. The revised questionnaire contained questions relating to seven relationships pertinent to a trainee's role: clients/service users, fellow trainees, clinical supervisor, placement team, University staff, employing Trust and personal relationships. Trainees were invited to complete the questionnaire in relation to their current placement (not reported here) and their overall experience of training so far.

For each relationship, trainees were asked an investment question, '*How much do you put into the relationship you have with X?'* and an outcome question, '*How much do you get back in return from your relationship with X*? Participants used a 5-point Likert scale from 1 (very little) to 5 (very much). Investment to outcome ratios were calculated by dividing the investment

score by the outcome score. A score of 1 was considered to show a perfectly reciprocal relationship with a score less than 1 indicating less was invested than received, whereas a score greater than 1 indicated more was invested than received. As reciprocity is measured in a ratio form, then the calculation of linear correlations may provide biased estimates for values less than 1. Accordingly, the reciprocity ratio was made to be linear by taking the negative of the reciprocal of values less than 1.

Maslach Burnout Inventory

The Maslach Burnout Inventory (MBI; Maslach and Jackson, 1986) measures levels of burnout along three subscales: depersonalisation, emotional exhaustion and personal accomplishment. The present study used the Human Services Survey version, designed specifically for professionals working in human services. Participants rate 22 statements of work-related feelings (e.g. *'I feel depressed at work'*) using a 6-point Likert scale with responses ranging from 0 (never) to 6 (every day).

Warwick-Edinburgh Mental Well-being Scale

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS; Tennant et al, 2007) is a positively-worded questionnaire designed to measure perceived well-being and psychological functioning (e.g. '*I've been dealing with problems well*'). Participants rate 14 statements on a Likert scale ranging from 1 (none of the time) to 5 (all of the time).

Self-Efficacy

The Clinical Psychology Inventory (CPI) is a measure of self-efficacy specific to clinical psychology training (Matharu, 2012). The scale comprises 3 subscales: clinical, academic and general self-efficacy. Participants rate their degree of confidence in performing each of 35 tasks on a scale of 1 – 100 (e.g. '*Work effectively with a service user group you've not worked with before*').

Statistical and Power Analysis

The data was analysed with SPSS using correlation and regression analysis. The regression had 13 independent variables. A power analysis was conducted for the regression analysis using Cohen's (1988) conventions for describing effect sizes as small, medium or large, the proposed study would require approximately 173 participants in order to identify a small effect, 54 participants in order to show a medium experimental effect and 31 participants to show a large experimental effect (power = 0.80; alpha = 0.05 two-tailed; multiple regression with 13 predictor variables). Accordingly, the proposed sample size of approximately 230 participants would be sufficient to evaluate moderate or even small effects.

Results

Demographic Information

26 out of 34 (76.5%) Course Directors agreed for us to approach their trainees. The sample of 214 trainee respondents consisted of 24 men (11.5%) and 185 women (88.5%), aged 23 – 55 years (*M* = 29.46; *SD* = 4.64). The total response rate from those

who initially agreed to complete the online questionnaire was 82%, 109 trainees were in year 2 (50.9%), 102 trainees in year 3 (47.7%), one trainee in year 4 (0.5%) and two in year 5 (0.9%).

Data Analysis

Descriptive statistics

The relationship reciprocity ratio scores for clinical training are presented in Table 1. The mean scores indicate that overall on the course, trainees reported they invested less than they received back in most of the relationships measured. This was especially the case with University staff. In contrast, trainees unsurprisingly reported more investment in their relationship with clients, and to a lesser extent NHS placement teams, than they received in return.

Insert table 1 about here

The mean scores for the burnout, well-being and self-efficacy measures are presented in Table 2. The mean well-being score on the WEMWBS of 48.41 was slightly lower than the population mean of 51.61 (Health Survey for England, 2011).

Insert table 2 about here

Correlations between relationship reciprocity, self-efficacy, psychological well-being and burnout are presented in Table 3. Given the large number of correlations

conducted, the significance level was set at 0.005, rather than 0.05 in order to avoid multiple comparisons leading to false positive correlations. However, it represented a less stringent threshold than some other methods such as the Bonferroni test, thus allowing an appropriate exploration of the data.

Significant correlations were found between some of the social exchange relationships and aspects of self-efficacy. In particular, reciprocity in relationships with clinical supervisors and placement teams correlated with all self-efficacy subcategories.

There were a number of significant correlations between social exchange relationships and aspects of burnout. Reciprocity with clients, with supervisors and with the placement team were correlated with emotional exhaustion, suggesting that investing more than receiving is associated with higher burnout. Reciprocity in relationships with clients/service users was also correlated with personal accomplishment, with investing more than receiving being associated with a lower sense of accomplishment.

In order to further investigate the effect of relationship reciprocity and self-efficacy on psychological well-being and burnout, a series of multiple regression analyses was conducted (Table 4). Blocked regression models, with the three self-efficacy variables entered in the first block and the seven social exchange relationships entered in the second block, produced significant models for all three MBI subscales and the well-being measure. The regression model significantly predicted emotional exhaustion, accounting for approximately 24.1% of the variance with self-efficacy accounting for the majority of this. The regression model significantly predicted

depersonalisation, accounting for 15% of the variance. The regression model significantly predicted personal accomplishment, accounting for 21.7% of the variance. Finally, the regression model significantly predicted psychological well-being, accounting for 40.7% of the variance.

Insert tables 3 and 4a & b about here

Discussion

The findings suggest that clinical psychology trainees experience levels of psychological well-being close to the population norm and have low levels of depersonalisation, indicating that trainees do not have especially poor psychological well-being. However, just over a third had a low sense of personal accomplishment and just over two-thirds were experiencing moderate/high emotional exhaustion. While the former may not be unexpected given the demands of training, the latter gives cause for concern and is further explored below.

The first hypothesis of this study, that the balance of investment in relationships is associated with and predicts burnout is partially supported, as the degree of investment in certain relationships was significantly positively correlated and was predictive of emotional exhaustion and lower sense of personal accomplishment. The regressions indicated that between 15% (depersonalisation) and 40% (well-being) of the variation in the independent variables related to stress and well-being were related to self-efficacy and reciprocity.

However, the variables that contributed to the variance in burn–out and well-being were not those anticipated. Our results suggest that reciprocity in relationships with clients is less influential than relationships with peers, supervisors and the University course team. Our findings suggest that over-investment in relationships with clients is correlated with emotional exhaustion. It is also the only social exchange relationship to be significantly correlated with personal

accomplishment and it makes a significant contribution to depersonalisation in the regression model.

The difference between our current findings and those of other studies may be related to the work context. The direct care staff who took part in previous studies conduct their day to day work in a particular position in a team in an openly hierarchical system. It may be that in these settings, peer and managerial relationships have greater influence on psychological well-being than for trainees who may have more autonomy than ward-based staff. This autonomy may lessen the influence of the peer group and those higher in the hierarchy on day-to-day stresses that build up to induce emotional exhaustion. In comparison to care and nursing staff, trainees' major purpose on placement is to be effective 'behind closed doors' in their therapeutic relationships with clients. This may give greater valence to their relationships with clients.

In line with the second hypothesis, reciprocity did not contribute to the variance in stress and well-being as much as anticipated. Reciprocity in relationships with the trainee cohort was related to emotional exhaustion. clients related to psychological well-being. Reciprocity in relationships with the trainee cohort also contributed significantly to explaining well-being scores. Reciprocity with clients and with others outside the work environment contributed significantly to depersonalisation. The findings imply that when trainees feel well supported (i.e. receive more than they invest), psychological well-being is engendered, which in turn protects against

emotional exhaustion. However, for trainees many of these relationships had little impact on stress and well-being.

Self-efficacy was much more significant in that it contributed large amounts of variance to the regressions with and predicted elements of burnout and psychological well-being, thus supporting the third hypothesis. In the regression models, perceived clinical self-efficacy predicts levels of perceived personal accomplishment and depersonalisation, and low course-related self-efficacy beliefs predict emotional exhaustion. As with the findings on social exchange with clients, these findings position the clinical element of training as central in promoting trainees' morale. Course and clinical self-efficacy beliefs jointly predict over 40% of the variance in psychological well-being. It is possible to speculate as to what else contributes to trainee well-being, for example, it is likely that home and personal circumstances will have a significant impact. Trainee resilience and the organisational context are also likely to have an impact; however, further research is required to investigate these potential contributions.

In summary, trainees have to negotiate a large number of relationships during their training and this study examined the influence of seven of these on burnout and psychological well-being. Four emerged as key: those with clients, clinical supervisors, the placement team and the course team. In addition, trainees' strength of belief in their ability to manage the clinical and general aspects of training had a significant impact on burnout and psychological well-being, whereas academic self-efficacy was neither correlated nor predictive of these outcomes.

Whilst trainees may not find academic components of training to be easy, they may be more predictable and controllable than the demands and self-doubt that arise

from clinical demands. One of the implications is that to support trainees effectively, courses and supervisors need to ensure they have a good understanding of the sort of input that makes trainees feel supported in their clinical work. The role of self-efficacy beliefs appear to be central and further research on how to enhance these beliefs in relation to clinical aspects of training is required.

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Table 1: Mean reciprocity ratios and percent of trainees reporting over and under invested relationships on training overall.

	Reciprocity score		Over-invested	Balanced	nder-invested
	Mean	SD	%	%	%
Client/service users (overall)	**1.21***	0.42	48.3	51.2	0.5
Clinical supervisor (overall)	0.92	0.68	21.2	71.5	7.3
Cohort (overall)	0.88	0.82	15.2	75.1	9.7
Placement team (overall)	**1.03***	0.68	29.3	65.4	5.3
Personal relationships (overall)	0.84	0.82	16	73.8	10.2
Trust (overall)	0.83	0.86	9.6	81.1	9.3
University staff (overall)	0.70	1.23	17.6	62.7	19.7

*Note. * Reciprocity score of more than 1 = more is invested in the relationship ('over-investment')*

Table 2: Mean scores and trainee percentages for self-efficacy, well-being and burnout

	Mean	SD	%	Medium %	High %	
MBI: depersonalisation	3.18	3.33	86.4	12.1	1.4	
MBI: emotional exhaustion	21.65	9.39	32.2	36.9	30.8	
MBI: personal accomplishment	36.14	5.82	36	42.1	22	
Well-being	48.41	6.98	13.6	83.6	2.8	
Self-efficacy: academic	74.25	14.30				
Self-efficacy: clinical	70.78	11.52				
Self-efficacy: general course	64.53	16.05				

Note: Low, medium or high MBI scores were categorised according to the manual (Maslach and Jackson, 1996) and Well-being scores according to NHS Scotland, 2013.

Table 3: Spearman's rho correlational analysis between self-efficacy, reciprocity, well-being and burnout

Subscale	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Client														
2. Clinical supervisor	**.197****													
3. Cohort	.092	.058												
4. Placement team	**.226****	**.372****	**.140***											
5. Personal relationships	.133	-.037	**.152***	.079										
6. Trust	-.082	.040	.063	.072	-.007									
7. University staff	-.064	.059	**.320****	.007	.088	.134								
8. MBI: DP	.130	.082	-.030	.078	.069	-.081	-.071							
9. MBI: EE	**.146***	**.191****	.030	**.201****	.114	.011	.073	**.365****						
10. MBI: PA	**-.195****	-.075	-.005	-.121	-.039	.116	-.113	**-.167***	**-.152***					
11. Well-being	-.097	**-.172***	-.080	**-.231****	-.054	-.076	**-.172***	**-.146***	**-.400****	**.363****				
12. SE: academic	**-.143***	**-.201****	.018	**-.172***	-.052	.013	**-.197****	**-.135***	**-.225****	**.326****	**.390****			
13. SE: clinical	**-.191****	**-.212****	.038	**-.209****	-.072	**.166***	-.055	**-.235****	**-.296****	**.473****	**.411****	**.605****		
14. SE: course	-.103	**-.160***	-.131	**-.192****	-.025	.029	-.110	**-.165***	**-.386****	**.316****	**.605****	**.647****	**.554****	

Note. * Significant to $p<.005$. ** Significant to $p<.001$

Table 4a: Summary of blocked hierarchical regression analysis showing the predictors of well-being and burnout (N = 214)

	Emotional exhaustion				Depersonalisation			
	Block 1 r^2 =.216				r^2 =.092			
	Block 2 r^2 =.241				r^2 =.152			
Specific Measure	*β*	*Stand Beta*	*T*	*Sig.*	*β*	*Stand Beta*	*T*	*Sig.*
Block 1								
Self-efficacy (clinical)	-.094	-.122	-1.33	.183	-.082	-.278	-3.07	.002[*]
Self-efficacy (academic)	.059	.090	.975	.331	.028	.120	1.204	.230
Self-efficacy (course)	-.268	-.452	-5.12	.000[**]	-.030	-.140	-1.47	.141
Block 2								
Self-efficacy (clinical)	-.066	-.079	-.901	.369	-.068	-.229	-2.47	.014[*]
Self-efficacy (academic)	.061	.094	.982	.327	.020	.086	.852	.395
Self-efficacy (course)	-.284	-.478	-5.25	.000[**]	-.033	-.156	-1.62	.107
Reciprocity (cohort)	-.802	-.065	-.944	.346	-.165	-.038	-.517	.606
Reciprocity (university)	.137	.018	.254	.799	-.306	-.112	-1.51	.133
Reciprocity (clients)	2.54	.115	1.763	.080	1.11	.141	2.044	.042[*]
Reciprocity (clinical supervisor)	1.24	.085	1.225	.222	-.16	-.032	-.440	.660
Reciprocity (placement team)	-.427	-.030	-.421	.674	.132	.026	.347	.729
Reciprocity (trust)	-.028	-.003	-.038	.969	-.234	-.060	-.862	.390
Reciprocity (personal)	.449	.038	.596	.552	.580	.140	2.049	.042[*]

Note. [*] Significant to *p*<.05. [**] Significant to *p*<.01

Table 4b: Summary of blocked hierarchical regression analysis showing the predictors of well-being and burnout (N = 214)

	Personal accomplishment Block 1 r^2 = .191 Block 2 r^2 = .217				Well-being r^2 = .390 r^2 =.407			
Specific Measure	β	Stand Beta	T	Sig.	β	Stand Beta	T	Sig.
Block 1								
Self-efficacy (clinical)	.182	.358	4.201	**.000****	.110	.179	2.420	**.016***
Self-efficacy (academic)	.009	0.23	.246	.806	-.04	-.08	-1.06	.291
Self-efficacy (course)	.035	.097	1.079	.282	.245	.56	7.250	**.000****
Block 2								
Self-efficacy (clinical)	.192	.378	4.254	**.000****	.123	.200	9.162	**.000****
Self-efficacy (academic)	.005	.014	.140	**.000****	-.055	-.114	2.594	**.010***
Self-efficacy (course)	.026	.071	.767	.889	.243	.558	-1.350	.179
Reciprocity (cohort)	-.024	-.003	-.045	.444	.023	.003	6.928	**.000****
Reciprocity (university)	-.378	-.081	-1.135	.964	-.454	-.080	.043	.966
Reciprocity (clients)	-.271	-.020	-.303	.258	-.415	-.026	-1.300	.195
Reciprocity (clinical supervisor)	1.177	.132	1.869	.762	.681	.063	-.444	.658
Reciprocity (placement team)	-.120	-.014	-.192	.063	-.520	-.050	1.031	.304
Reciprocity (trust)	.410	.062	.921	.848	-.641	-.080	-.792	.430
Reciprocity (personal)	-.014	-.002	-.030	.358	.186	.022	-1.372	.172

Note. *Significant to $p<.05$. **Significant to $p<.01$