

**Trainee Therapist Goal Conflict and its Relationship to
Perceptions of Goal Attainment and Occupational Stress**

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D.Clin.Psy Thesis (Volume 1), 2017

University College London

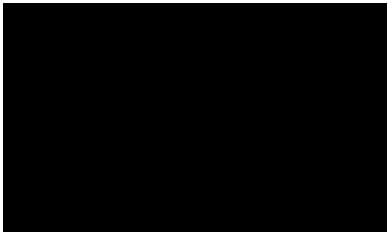
Declaration

UCL Doctorate in Clinical Psychology

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:



Name: Samuel Russ

Date: 10.12.2017

Overview

A central theme to this three-part thesis is what factors predict burnout in trainee psychologists. Part One is an original systematic narrative review which examined what factors have been observed in quantitative research to be associated with levels of stress and burnout in this population. The review organised variables into broad themes including demographics, self-care/social support, and personality/coping styles. Studies tended to investigate factors already known to impact upon stress levels in the general population, but these are discussed as useful to be aware of as moderating the relationship between challenges inherent in professional psychology training and the outcomes of stress and burnout.

Part two is empirical research conducted to explore if goal conflict predicts burnout and goal progression in Trainee Clinical Psychologists. The results supported the hypotheses (and past findings) that reduced burnout would be associated with greater goal facilitation when goals were examined at the level of more abstract values and needs, and that greater ambivalence felt about goals would be associated with perceived reduced goal attainment. The overall findings (including non-significant results) are discussed in relation to the goal conflict literature, and the current study's limitations.

Part three details my reflections on conducting this research, including about the conceptual and methodological weaknesses of goal conflict research. Considerations for future studies are noted.

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Acknowledgements

I would like to thank Dr. Vyv Huddy, for his invaluable guidance and support, both from the beginning of training and throughout the research project. You have been an inspiring supervisor.

I would also like to acknowledge Richard Pender for the added humour and containment throughout this process. This work is dedicated to the memory of Wolf Lauterbach, for his contribution to goal conflict research and Psychology.

Part One: Literature Review

Factors Associated with Stress and Burnout in Trainee Psychologists

Abstract

Aims: To explore evidence from the literature which examine factors associated with stress and burnout in Trainee Psychologists. This might have implications for increasing the professional efficacy in what research has suggested to be a group potentially vulnerable to high levels of occupational stress and impairment.

Method: A systemic literature search was performed on the databases PsycINFO and Medline. Only quantitative studies employing measures of stress or burnout were included. Seventeen studies made up the narrative synthesis. Grey literature was not excluded due to this being a relatively understudied area.

Results: The review highlighted three broad themes which were associated with stress and burnout; demographics, self-care/social support, and personality/coping styles. The studies did not typically highlight unique stressors for this group, but examined factors known to influence stress in the general population. It appeared these factors might help to understand what predicts or protects against increased stress in the context of the challenges inherent in clinical training.

Conclusions: There was consistent evidence across studies for the influence of factors which predict stress and burnout in trainee psychologists, and there are likely interactions between these factors which might put particular trainees at greater risk. Implications for psychology training programmes about how to target these factors are outlined, which might reduce the potential for elevated stress during training, and provide a foundation for long-term professional well-being.

Introduction

Stress is commonly defined as “a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p.19; Pakenham & Stafford-Brown, 2012). A related construct is burnout, which is a form of work-related stress involving emotional exhaustion, depersonalisation and lack of personal accomplishment (Maslach & Goldberg, 1998; Pakenham & Stafford-Brown, 2012). The negative outcomes of stress and burnout are widely documented in health-care professionals which include reduced affective well-being, impaired occupational functioning, absenteeism, poor morale, mental and physical illness and workforce turnover (Jenaro, Flores & Arias, 2007; Ruotsalainen, Verbeek, Mariné & Serra, 2014; Sutherland & Cooper, 1990). Research suggests that between 21-67% of mental health workers suffer high burnout levels (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012). Psychologists may be especially at elevated risk of burnout due to both the context and content of their work. For example, in terms of context, psychologists are working in isolated and resource-limited environments, while in terms of content, psychologists are exposed to emotionally challenging and sometimes traumatic material (Anagnostopoulos & Niakas, 2010; Grant & Campbell, 2007; Grigsby, 2016, Jenaro et al., 2007; Linley & Joseph, 2007). A recent review suggested UK Clinical Psychologists typically find their work demanding and stressful, reporting high-levels of emotional exhaustion, and as much as 40% revealing ‘caseness’ levels of distress (Hannigan, Edwards & Burnard, 2016). Mahoney’s (1997) survey of 155 psychologists also found that 43% reported emotional exhaustion from the year prior, with 42% doubting how effective their practice was.

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Pakenham and Stafford-Brown (2012) highlight how, in contrast to research on qualified psychologists, there is a dearth examining stress in trainee Clinical Psychologists. However, Cushway's (1992) survey found 75% of 287 UK-based trainees reporting moderate or high-stress from training. This finding is supported by considerable evidence that beginning therapists/counsellors are especially vulnerable to occupational stress (for review see Skovholt & Ronnestad, 2003). Some preliminary work (mostly commentaries and articles) have highlighted factors which appear to be significantly stressful during training (Cushway, 1992; Millon, Millon, & Antoni, 1986, Pakenham & Stafford-Brown, 2012, Pica, 1992, Skovholt & Ronnestad, 2003). These related to the rigorous academic component of programmes, placement demands (e.g. large caseloads and limited time-resources) and clinical challenges (surrounding ethical dilemmas and the ambiguity intrinsic to the practice of therapy). Personal characteristics were also important, such as self-doubt and unmet 'glamourised expectations' (Skovholt & Ronnestad, 2003, p. 53) about the nature of training and being a therapist. Further, trainees must also regularly switch between being a therapist, academic student and researcher, and face high-evaluation stress across roles (Cahir & Morris, 1991; Schwartz-Mette, 2009). In addition, like qualified psychologists and other human-service professionals, trainee psychologists have placements in clinical contexts associated with stress and burnout, but also have additional training stressors, such as the aforementioned academic demands. Therefore, taking preliminary research suggesting that trainee psychologists experience a range of stressors, and might face considerable stress during training, and extrapolating from findings with similar populations (e.g. beginning therapists and other mental health workers), it appears

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reasonable to expect that trainee psychologists might be vulnerable to stress-related impairment (Pakenham & Stafford-Brown, 2012).

Due to the well-documented negative consequences of chronic stress and burnout (Sutherland & Cooper, 1990), not only could the cost be to the personal and professional well-being of trainees, it could also lead to inadequate care for service-users. Evidence has shown that psychologists themselves recognize the consequences of stress-related impairment for potential harm to clients (Smith & Moss, 2009). For example, one study found 85% of practitioners stating that to work when too distressed is unethical (although 60% revealed having practiced regardless) (Pope et al., 1987), and another found that 36.7% of psychologists who were distressed felt this lowered the quality of care they offered, with 4.6% suggesting it was substandard (Guy, Poelstra & Stark, 1989). Further, although not specific to stress, evidence shows at least 25% of Clinical Psychology trainees reporting significant issues with depression, anxiety, self-esteem and work-adaption, which compromised their ability to appropriately and resiliently approach the tasks of learning and working (Kuyken, Power, Peters & Lavender, 2003).

Findings from the British Psychological Society and New Savoy well-being survey highlight that while there has been a focus on reaching targets to improve access to evidence-based therapies and improve the mental health of the nation, this has arguably been at the cost of the general psychological workforce, who report reduced well-being (Rao et al, 2016). Indeed, recognising the impact of stress and burnout in the context of rising workloads, the NHS has committed to investing an extra £2.4 billion a year into a resilience programme to support and sustain general practices (General Practice Forward View, 2016). However, to date, no systematic review has examined quantitative studies investigating what factors are associated

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with stress and burnout in trainee psychologists, which addressing might contribute to their well-being and resilience. As noted, there could be factors unique to this group, such as their dual-roles as mental health workers and postgraduate students, and unmet high expectations around what clinical training/therapy involve. Hence, standard occupational health advice might not suffice. It might also highlight factors which are protective or increase the risk for stress in response to stressors inherent in training. For example, the aforementioned research (Kuyken et al., 2003) examining work and psychological adaption in trainee Clinical Psychologists, implicated the roles of work-based support, appraisals of the demands of training as controllable, and lower use of avoidant-coping as protective. As it can be said that psychology training is a formative experience where students can learn adaptive skills in preparation for future professional functioning (Kuyken et al., 2003), becoming aware of if these factors, amongst others, similarly relate to stress levels in trainee psychologists would be useful for helping them to develop the skills to reduce on-going chronic occupational strain and prevent burnout in later stages of their careers. Indeed, Hurst, Kahan, Ruetalo and Edward (2013) highlight that research has recently attended to ‘critical incidents’ during medical student residency, which can both become long-term sources of distress and contribute to personal development. This review might similarly highlight significant stressors (or factors moderating stress) during what might be considered the critical period of psychology training, which might have long-standing implications for their professional functioning. Burnout has also generally been linked in students to course attrition and delayed completion (Deary, Watson & Hogston, 2003), which highlights the potential financial cost of unmanaged stress in funded trainees.

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This review therefore hopes to explore the question of ‘what factors are associated with occupational stress or burnout in trainee psychologists?’. Due to the aforementioned lack of research with trainee Clinical Psychologists, it will extend its entry criteria to Counselling Psychology trainees because of the convergence of these fields (e.g. Brems & Johnson, 1996), as well as where studies include other branches of psychology trainees alongside these program types. A narrative synthesis was viewed as appropriate for building up a broad theoretical picture about what factors are associated with stress/burnout in trainee psychologists from studies investigating diverse domains (Baumeister, 2003).

Method

Search Strategy

A systematic search was performed on the electronic databases PsycINFO and MEDLINE, and included papers from the beginning of records to the 18th of September 2016. The range of terms for trainee psychologists were informed by studies returned by an initial scoping search on PsycINFO. For example, it became apparent that American studies often referred to trainee psychologists as ‘graduate psychologists’. Regarding terms for stress/burnout, a search for ‘Burnout’ in the database thesaurus highlighted that it was listed under the subject heading ‘Occupational Stress’. ‘Occupational Stress’ was then searched as a Subject Heading, which lead to the associated terms of Job Stress and Work Stress. Examining the ‘Broader’ and ‘Related’ terms, ‘Compassion Fatigue’, ‘Occupational Neurosis’ and ‘Quality of Work Life’ were added as they appeared related to the research question. In total, the following terms were used:

(trainee psychol* OR psychology train* OR trainee clinical psychol* OR trainee

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counselling psychol* OR psychologist in train* OR psychologists in train*OR
training psychol* OR graduate psychol* OR graduate clinical psychol* OR graduate
psychol* OR psychology graduate* OR graduate counselling psychol* OR doctoral
psychol* OR student psychol*) AND (occupational stress OR stress OR burnout OR
job Stress OR work Stress OR compassion fatigue OR occupational neurosis OR
quality of work life OR exhaustion)

Inclusion and Exclusion Criteria

Inclusion criteria:

- Studies using stress/burnout measures and exploring (e.g. via correlation, regression, factor analysis) their relationship to predictor variables.
- Studies stating participants were either seeking a Doctoral qualification in Clinical or Counselling Psychology and/or stating participants were enrolled on APA (American Psychological Association) Accredited or BPS (British Psychological Society) Registered Clinical or Counselling Psychology programmes. This was to allow for a fairly homogeneous population to be compared. It is noted that American Clinical Psychology programs are currently offered as a Ph.D, or a Psy.D, whereas the UK equivalent is the D.Clin.Psy.

Exclusion criteria:

- Studies using qualitative methods with no quantitative component (e.g. interview-based methods only).
- Studies using only qualified psychologists.

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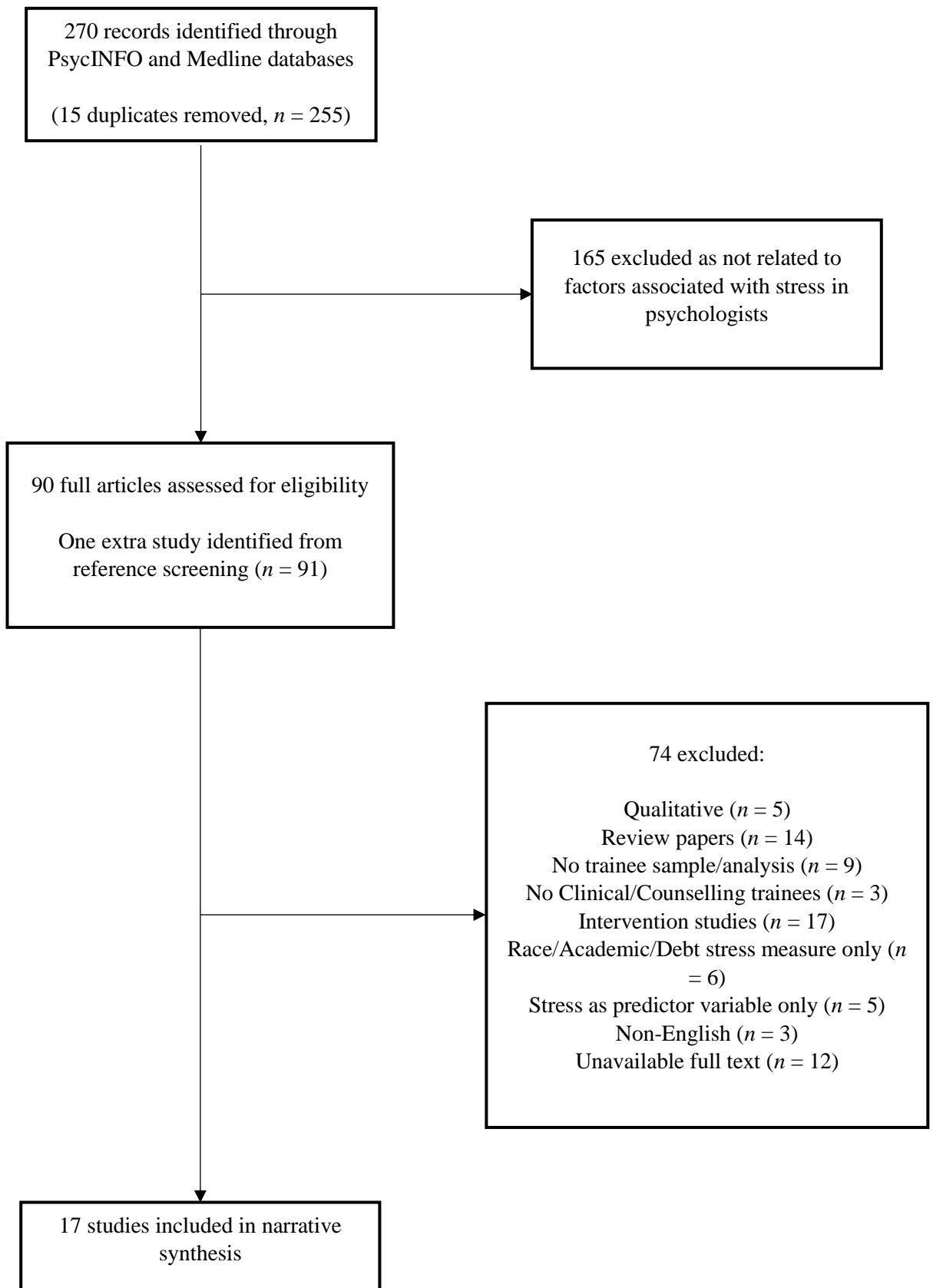
- Unless Clinical/Counselling Psychology trainees are part of its wider participant group, studies recruiting specialised branches of psychology (e.g. Forensic only).
- Studies not employing a general or work-specific stress/burnout measure (e.g. academic or race stress measures only).
- Studies not published in English.

Study Selection

A flow diagram of studies from screening to inclusion is depicted in Figure 1. In total, 245 studies were returned by the PsycINFO database and 25 by the MEDLINE database search. Fifteen duplicates were removed, leaving 255 papers. Title and abstract screening of each study occurred to determine suitability, and then the full text read of those relating to the research question. Twelve which appeared potentially relevant were unavailable on the databases (these were predominantly written prior to 1990, and for three of these no abstracts were provided). Screening of references identified one further study. Due to only a small number of studies appearing in peer-reviewed journals ($n = 6$), the search did not exclude full dissertation abstracts. In total, 17 studies were included in the narrative synthesis.

Figure 1

Flowchart of Study Selection



Methodological Limitations

Studies included. Only 6 of 17 papers were published in journals; the remaining 11 were submitted doctoral dissertations. As Pakenham and Stafford-Brown (2012) noted, stress in trainee psychologists has been an under-researched area, and due to the few published articles found, it was decided to include unpublished papers in this review. As these studies have not been reviewed by expert peers, the quality of their methodological rigour might be suboptimal. For example, Egger, Juni, Bartlett, Holstein and Sterne (2003) found unpublished studies less likely to have appropriate blinding of outcomes, and inadequate concealment of participant allocation to treatment groups. While these weaknesses are not so applicable to the cross-sectional studies in the current review, it is possible that methodological quality standards differ between the published and unpublished papers. In particular, limited information about the samples used in the unpublished studies is discussed in the next paragraph. Design weaknesses of all individual studies included in this review will also be discussed where apparent. However, it has been highlighted that not excluding unpublished literature might help overcome publication bias; two Cochrane reviews found that positive rather than negative (null) results were more likely to be published (Hopewell, Clarke, Stewart & Tierney, 2007). Published studies also typically report greater effect sizes (Hopewell, McDonald, Clarke & Egger, 2007). Indeed, acceptance of inclusion of grey literature by researchers and editors has increased over time (Tetzlaff, Moher, Pham & Altman, 2006).

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The inclusion/exclusion criteria aimed to determine a fairly homogeneous population by only including studies which explicitly mentioned that participants were enrolled on accredited or doctoral-level qualifications in Clinical/Counselling Psychology. However, it is noted that demands on trainees may still have varied significantly across programmes, and due to the limited research available, the review has drawn upon data from samples which might not be comparable. There could be notable differences in the quality of accredited and non-accredited programmes, such as in terms of what is required to pass. For example, as with the BPS, the APA state that internship experience is required of doctoral training (Micheli, 2015). However, only seven studies explicitly stated if the doctoral courses were accredited by the APA or the BPS, and another study stated only that 94% of their participants were on APA accredited programmes. The remaining nine made no reference to the accreditation status of the courses, and of these, five made no reference to clinical work being undertaken by the training psychologists. What was reported by the studies are outlined in Table 1. While this does not mean the programmes were not accredited or required field work, the lack of clarity around this means this review has attempted to group together trainee psychologists from what might be considerably different types of trainings. For example, the study only using online students may have little relationship with the programmatic expectations of traditional universities, although the authors (Grigsby, 2016) note that while not all trainees had clinical experience, on average 1.57 quarters of fieldwork were completed by participants. Furthermore, even where studies used all accredited programmes, they often recruited a mixture of Ph.D and Psy.D students which have a differing emphasis on clinical and academic components (the former emphasising research over practice), again perhaps making comparisons difficult.

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The peer-reviewed studies (four of the six) generally made more reference to whether trainings were accredited when compared to the dissertation studies (only four of the nine), highlighting a potential weakness of the grey literature used.

Design of studies. A major weakness is that because all studies were cross-sectional, and often only used correlational analyses, causality cannot be assumed.

Sampling. Bias could have arisen through all studies relying on convenience sampling (Barker, Elliott & Pistrang, 2002). There was also a fairly wide variation in sample sizes, from 67 to 488 participants. Statistical validity might be compromised in studies with smaller samples because the power to detect small effects is reduced. It is also noted that most studies acknowledged that participants were mainly female and Caucasian. While this may appear to weaken external validity, such a homogeneous sample reflects wider psychology demographics (e.g. under-representation of minorities and less male trainees) (Townsend, 2011).

Measures. Although there was occasional consistency between outcome measures (for example the PSS), different stress/burnout measures were often employed (for example, four types of burnout inventories) (see Table 1). However, these were all established measures which had high reported validity and reliability, and it would be expected that they were tapping into similar constructs. This appeared to be more problematic for the four studies which used stress surveys which have limited past use (three were designed for the purpose of each study). Of these, one (PSSM) reported details of average reliability and another (CPTSS) only reported it being piloted on trainees to improve validity. However, this latter survey was later used in another study, which performed tests of reliability and found it to score within the average range. Importantly, all measures of stress/burnout relied on

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subjective self-report which can be unreliable and prone to social-desirability bias (Barker et al., 2002; Orne, 1962).

Mol et al. (2015) highlight that burnout is related to compassion fatigue, but is believed to differ in specific ways. Burnout is expected to relate to work-related factors including practitioner autonomy, caseload, and the presence or not of rewarding relationships (Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013) whereas compassion fatigue is related to being unable to take part in the caring relationship with the service-user (Sabo, 2011). However, significant positive associations between these concepts have been found, which captures the likely shared underlying processes involved (Mol et al., 2015). Moreover, while this review focused on stress and burnout, it is noted that compassion fatigue was included as a related search term of burnout, and that a variety of burnout measures were employed by studies which incorporated this construct. Therefore, there might be expected overlap in terms of the factors associated with compassion fatigue as those found with burnout in this study.

Table 1

Nature of Trainee Psychologist Samples across Studies

Paper	Source	Accreditation / Clinical experience of programmes	Training institution
Armstrong, 2015	Dissertation Study	All APA Accredited	Traditional
Bowlin, 2014	Dissertation Study	Not stated. Clinical experience not stated either	Traditional
Cahir and Morris, 1991	Journal Article	Not stated. Clinical experience not stated either	Traditional
Clark, Murdock and Koetting, 2009	Journal Article	Not stated. Clinical experience not stated either	Traditional
Cushway, 1992	Journal Article	All BPS Accredited	Traditional
Drake, 2011	Dissertation Study	Not stated. Clinical experience not stated either	Online and traditional
El-Ghoroury, Galper, Sawaqdeh & Bufka, 2012	Journal Article	All APA Accredited	Traditional
Grigsby, 2016	Dissertation Study	Not stated. Does state that not all programs involved clinical experience (average 1.57 quarters of fieldwork completed)	Online
Kumary and Baker, 2008	Journal Article	All BPS Accredited	Traditional
Micheli, 2015	Dissertation Study	All APA Accredited	Traditional
Montgomery, 2010	Dissertation Study	All APA Accredited	Traditional
Myers et al., 2012	Journal Article	94% APA Accredited	Traditional
Riise, 2012	Dissertation Study	All APA Accredited	Traditional
Scarborough, 2009	Dissertation Study	Not stated. However, noted all trainees have or are engaged in clinical experience	Traditional
Shaw, 2013	Dissertation Study	Not stated. Clinical experience not stated either	Traditional
Shotwell, 2014	Dissertation Study	Not stated. However, noted that participants had clinical experience	Traditional
Townsend, 2011	Dissertation Study	Not stated. 17.6% were having clinical experience	Traditional

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Table 2

Burnout/Stress measures used across studies

Type of stress/burnout measure	Measure / Basic information	Study used
Established Burnout Measures	<i>Maslach Burnout Inventory Student Survey</i> (MBI-SS; Schaufeli et al., 2002). For use with university students. Measures domains of Emotional Exhaustion (Ex), Cynicism (Cy) and Professional Efficacy (Ef)	Grigsby, 2016
	<i>Maslach Burnout Inventory - Human Services Survey</i> (MBI-HSS; Maslach & Jackson, 1981). Measures domains of Emotional Exhaustion (Ex), Depersonalization (Dp), Personal Accomplishment (Pa)	Scarborough, 2009
	<i>Counselor Burnout Inventory</i> (CBI; Lee et al., 2007). Assesses burnout in counsellors (Exhaustion, Competence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life).	Micheli, 2015
	<i>Psychologist Burnout Inventory</i> (PBI; Ackerley, Burnell, Holder & Kurdek, 1988). Assesses burnout in psychologists <i>Meier Burnout Assessment</i> (MBA; Meier & Schmeck, 1985). Measures college student burnout	Riise, 2012 Clark, Murdock & Koetting, 2009
Established Stress Measures	<i>Perceived Stress Scale</i> (PSS-14; Cohen, Kamarck, & Mermelstein, 1983). 14-item version measuring perceptions of stress	Drake & Krystal, 2011, Myers, Sweeney, Popick, Wesley, Bordfeld &; Fingerhut, 2012, Townsend, 2011, Shaw, 2013, Bowlin, 2014

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	(PPS-10) (10 item version)	Armstrong, 2015
	(PPS-10) (10 item version) (modified to investigate both personal and professional stress)	Montgomery, 2010
	<i>The Therapeutic Stresses Rating Scale</i> (TSRS; Farber & Heifetz, 1981; modified by Heilman et al., 1986). Measures stress in Therapeutic Relationship, Scheduling, Professional Doubt, Work Overinvolvement, and Personal Depletion	Shotwell, 2014
Stressor surveys designed for study	<i>Stress Survey</i> . Identified academic, placement, organisational, and personal stressors in trainees	Cushway, 1992
	<i>Counselling Psychology Trainee Stress Survey</i> (CPTSS). Developed from Cushway's (1992) survey of stressors (above)	Kumary & Baker, 2008
	<i>Psychology Student Stress Questionnaire</i> . Assesses academic, emotional, and financial stressors during training	Cahir & Morris, 1991
	<i>Psychology Student Stress Measure</i> (PSSM). Covers life events, as well as academic/interpersonal stressors of psychology graduate students reported in the literature	El-Ghoroury, Galper, Sawaqdeh & Bufka, 2012

Results

The synthesis identified three broad themes in the factors associated with stress/burnout across studies; trainee/placement demographics, self-care/social support, and personality/coping styles. The following three tables correspond to each theme, and describe the results of studies which are specific to that theme. As study findings often related to more than one theme, where this occurred the study is repeated across tables. Stress/burnout measures used across studies are shown in Table 1. Measures of predictor variables associated with Stress/Burnout across studies are shown in Appendix A. Years of studies ranged from 1991 to 2016.

Association Key (Cohen, 1988):

+++ Strong (Positive)	--- Strong (Negative)
++ Moderate (Positive)	-- Moderate (Negative)
+ Weak (Positive)	- Weak (Negative)

Trainee and Placement Demographics

Table 3

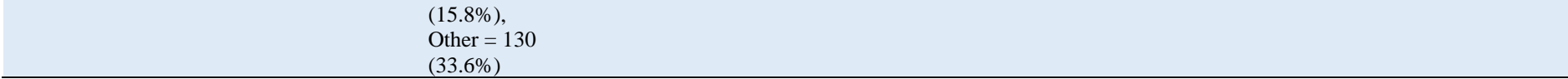
Studies investigating Demographics and Stress/Burnout

Author(s)/Year	Source	Design	Participants (including type (if reported)/Country)	Predictor variable Measure(s)	Outcome (Burnout / Stress) Measure(s)	Main findings	Moderator
Cushway, 1992	Journal Article	Cross-sectional	287 Trainee Clinical psychologists (UK)	<i>Demographics</i>	<i>Stress Survey</i>	Gender, and Year in training and Stress (significant differences) Type of training course, Length of training, Funding, Age, Relationship status and Stress, ns	
Kumary and Baker, 2008	Journal Article	Cross-sectional	109 Trainee Counselling Psychologists (UK)	<i>Demographics</i>	<i>CPTSS</i>	Gender, and Age and Stress (significant differences) Year in training and Stress, ns	
Cahir and Morris, 1991	Journal Article	Cross-sectional	133 Trainee Clinical Psychologists (America)	<i>Demographics</i>	<i>PSSQ</i>	Gender, and Year in training and Stress (significant differences)	
Montgomery, 2010	Dissertation Study	Cross-sectional	591 (America) Clinical Ph.D. = 121 (21%), Clinical Psy.D. = 256 (43%), Counseling = 90 (15%), School = 124 (21%)	<i>The Intervention Questionnaire, SWLS</i>	<i>PSS-10</i>	Relationship status, and Year in training and Stress (significant differences) Program type, Age, Gender and Stress, ns	

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Myers et al., 2012	Journal Article	Cross-sectional	488 (America) PsyD = 120 (24.6%) PhD = 282 (57.8%) Other = 86 (17.6%)	Demographics	PSS-14	Stress and: Age - Cost of living to income ratio - Relationship status and Stress (significant differences) Type of training program, Race, Location and stress, ns
Armstrong, 2015	Dissertation Study	Cross-sectional	70 Psy.D and Ph.D.(America)	Demographics	PSS-10	Year in training, Age, Type of training program, Practicum experience and Stress, ns Placement satisfaction and burnout -
Micheli, 2015	Dissertation Study	Cross-sectional	142 (America) Clinical Psy.D = 85 (60.3%), Clinical = 40 (28.4%) or Counseling = 16 (11.3%) Ph.D	Demographics, JSS	CBI	Placement type, Field hours, Previous experience in mental health field, Education, Marital status and Burnout, ns
Scarborough, 2009	Dissertation Study	Cross-sectional	86 Trainee Clinical Psychologists (America)	WFQ	MBI-HSS (EE = Emotional Exhaustion, Dp = Depersonalisation, PA = Professional Accomplishment)	Autonomy and EE + Year in Practicum and DP + Disclosure to Co-worker and DP + Year in Practicum and Reduced PA + Disclosure to co-worker and Reduced PA -- Number of direct clinical hours and Reduced PA + Spirituality and Self-Assessed Burnout ++ Ethnicity/race and Stress (significant differences)
El-Ghoroury, Galper, Sawaqdeh & Bufka, 2012	Journal Article	Cross-sectional	387 (America) Clinical = 196 (50.6%), counseling = 61	Demographics	Psychology Student Stress Measure	

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Gender

Three studies found females significantly reporting higher stress. Cushway (1992) note their findings support most studies of American students (e.g. Lloyd & Gartrell, 1981). Cushway (1992) suggested that while female trainees might experience more stress, women might more openly express it than men. In contrast, two studies found gender and stress unrelated. Montgomery (2010) argued this might be due to their study being conducted later in time compared to Cushway's (1992) (and similarly it seems to Cahir & Moris, 1991) whereby cultural changes mean men are now perhaps more open to reporting stress, and are expected to deal more with (potentially stressful) responsibilities in the home. In addition, they state that psychology programmes might now be more flexible to the needs of women (see discussion).

Age

Two studies found age significantly related with stress, with younger participants rating stress scores higher and vice-versa, which Kumary and Baker (2008) speculate could be due to older trainees possessing more 'wisdom' to calmly manage placements, which also makes them more attractive to supervisors. Myers et al. (2012) state these findings fit with past research on how older individuals report less daily issues possibly due to them developing better coping strategies (Folkman, Lazarus, Pimley & Novacek, 1987). However, while three studies found stress not significantly related to age, two of these (Montgomery, 2010; Cushway, 1992) were trending in the same direction as the aforementioned papers. Cushway (1992) also acknowledge their study was underpowered due to having so few trainees in their forties.

Relationship Status

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Two studies found lower perceived stress for participants who were married or partnered. Myers et al. (2012) state this supports research on how marriage can provide helpful relational support, which has been associated with lower student stress (Craddock, 1996). Cushway (1992) found divorced and separated students reported significantly greater stress than those single, married, or in relationships. In contrast, two studies found relationship status (partnered, single, separated or divorced) unrelated with stress.

Year in Training

Cushway (1992) found trainees in Year 2 and 3 reported more stress than those in Year 1. They propose this may result from specific stressors in these years, or an accumulation of stress throughout training. Montgomery (2010) found second (but not third) year trainees reported greater stress. They suggest this may be because second-year students confront additional challenges (e.g. starting dissertation) already completed by third-years. However, Kumary and Baker (2008), and Armstrong (2015) found stress remained steady over training, although the latter researcher acknowledges that the chance of finding an effect might be low due to their small sample.

Program type

Three studies consistently found program type (e.g. Clinical, Counselling or School Psychology) unrelated with perceived stress.

Race

El-Ghoroury et al. (2012) found significant racial differences in prevalence of stressors identified by their stress survey, with minority trainees reporting discrimination as a greater stressor than Caucasian trainees, while the latter typically reported higher physical health issues and alcohol/substance abuse (although these

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were rare stressors).

Other

As would be expected, Micheli (2015) found higher placement satisfaction associated with reduced burnout, but no further information was provided about individual scales. Scarborough (2010) found greater work autonomy, and direct clinical hours associated with reduced burnout. Micheli (2015) found number of field hours, and placement type, unrelated to burnout. Finally, financial stability was related to reduced stress/burnout across two studies, which Myers et al. (2012) note is consistent with research in adult students (Sandler, 2000).

Self-Care and Social Support

Table 4

Studies investigating Self-care/Social Support and Stress/Burnout

Author(s)/Year	Source	Design	Participants (including type (if reported)/Country)	Predictor variable Measure(s)	Outcome (Burnout / Stress) Measure(s)	Main findings	Moderator
Shotwell, 2014	Dissertation Study	Cross- sectional	109 Psy D (America)	<i>WFQ</i>	<i>TSRS</i>	Overall self-care and: Work over-involvement - Scheduling issues - Personal depletion - Relationship self-care and: Work overinvolvement - Personal depletion - Self-care lifestyle factors and: Overall professional stress - Work overinvolvement - Scheduling problems - Personal depletion --	
Myers et al., 2012	Journal Article	Cross- sectional	488 (America) PsyD = 120 (24.6%) PhD = 282 (57.8%) Other = 86 (17.6%)	<i>GLTEQ, MPSS, The Sleep Hygiene Index, ERQ, Mindfulness questionnaire</i>	<i>PSS-14</i>	Stress and: Healthy sleep practices - Social support - Mindful acceptance -- Frequent exercise, Mindfulness practice, ns	
Townsend, 2011.	Dissertation Study	Cross- sectional	119 Doctoral Trainee Clinical/Counselling Psychologists	<i>MDSS, SWLS</i>	<i>PSS-14</i>	Satisfaction with Life and Perceived Stress ---	Social support, ns as moderator between

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(America)						stress and life satisfaction
Clark, Murdock and Koetting, 2009	Journal Article	Cross-sectional	284 (America) Counseling psychology (97%), Other (3%)	<i>Social Support Measure, Psychological SOC</i>	<i>MBA</i>	Burnout and: Global stress ++ Advisor support - SOC -
Montgomery, 2010.	Dissertation Study	Cross-sectional	591 (America) Clinical Ph.D. = 121 (21%), Clinical Psy.D. = 256 (43%), Counseling = 90 (15%), School = 124 (21%)	<i>The Intervention Questionnaire, SWLS</i>	<i>PSS-10</i>	Stress and: Relationship Intervention -- Adjunct Self-Care - Impairment Prevention -- Balanced Well-Being -- Overall Satisfaction and Professional Stress --
Armstrong, 2015	Dissertation Study	Cross-sectional	70 Ph.D. and Psy.D. (America)	<i>WFQ, QOLS</i>	<i>PSS-10</i>	Quality of Life and Perceived stress –
Scarborough, 2009	Dissertation Study	Cross-sectional	86 Trainee Clinical Psychologists (America)	<i>WFQ</i>	<i>MBI-HSS</i> <i>(EE = Emotional Exhaustion, Dp = Depersonalisation, PA = Professional Accomplishment)</i>	Self-growth and EE - Physical exercise and EE- Sense of calling to profession and Dp - Confession and Dp + Self-growth and Dp - Personal values and PA + Group physical exercise and PA - Sense of calling to profession and PA + Confession and PA - Overall Self-care and EE - Overall Self-care and DP - Financial stability and Overall Burnout +

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Shaw, 2013.	Dissertation Study	Cross-sectional	168 Psy.D (America)	<i>Creative Activities Survey</i>	<i>PSS-14</i>	Participation in one monthly creative activity and Perceived Stress --
Bowlin, 2014.	Dissertation Study	Cross-sectional	98 Psy.D (America)	Dyadactic Adjustment Scale	<i>PSS-14</i>	Relationship satisfaction and perceived stress, ns

Self-Care Behaviours

Both Shotwell (2014) and Scarborough (2009), using the WFQ, found engagement in, or ratings of the importance of specific well-functioning factors (e.g. relaxation, balancing personal and professional lives, self-growth, taking vacations, personal values, spiritual beliefs) predictive of reduced burnout. In line with theory exploring the relevance of self-care to lowering burnout (Freudenberger, 1974; Raquepaw & Miller, 1989; Skovholt, 2001), both also found lower overall self-care related to increased burnout. Shotwell (2014) argue that these activities likely lead to the heightened professional functioning of psychology trainees by improving their general well-being and reducing stress. However, Scarborough (2009) only used ratings for the importance of well-functioning factors, which might not reflect trainees' actual engagement with these. Interestingly, group exercise and confession were related to higher burnout, which they add could be due to chance significance findings. It is also noted that a sense of calling to the profession reduced burnout.

Myers et al. (2012) found healthy sleep behaviours, mindful acceptance (but not frequency of mindfulness practice) associated with reduced stress. Contrary to their hypothesis, exercise was unrelated. While they note low reliability of their exercise measure, they argue its benefits may be in relation to particular stressors, and the individual's beliefs about exercise as an effective coping strategy (Salmon, 2001). So, some trainees may have believed this to increase stress in the context of other demands. This may help account for Scarborough's (2009) finding on group physical exercise. Townsend (2011) found that trainees with higher life satisfaction typically reported less stress which might fit with the aforementioned results, as higher life satisfaction might be experienced by trainees engaging in various well-being enhancing activities.

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Shaw (2013) state that despite creative activities not being usually considered a self-care habit, participants who engaged in these at least once a month reported less stress (and more professional benefits). They propose these help the individual similarly to how studies demonstrate the benefits of activities which provide validation, mastery, pleasure, greater internal locus of control and relaxation (Adams-Price & Steinman, 2007; Griffiths, 2008; Holland, 2003; Medina, 2008; Morgan & Wampler, 2003).

Montgomery (2010) focused on more course-related aspects of self-care, exploring the impact of its encouragement by professional psychology programmes. These included Relationship Intervention (e.g. help-seeking is reinforced), Adjunct Self-Care Training (e.g. retreats for students), Impairment Prevention Training (e.g. talks on professional impairment), and Balanced Well-Being (e.g. trainee can meet program expectations and live a balanced life). The results highlighted the importance of self-care interventions to trainee wellbeing because the more trainees reported receiving, the less stress (as well as increased satisfaction) they reported. However, it is noted participants only rated if they experienced these, not their satisfaction with them. Interestingly, under 40% reported their training courses actively promoted fostering balanced lives, and just 10% reported self-care training outside lectures.

Social support/Relational Satisfaction

Shotwell (2014) found that cultivating relationships with friends/family reduced burnout. Myers et al. (2012) also found social support buffered stress, consistent with student research (Calicchia & Graham, 2006). Bowlin (2014) found no association between romantic relationship satisfaction and stress, but proposed that lack of satisfaction in-itself is not problematic, especially given relationships did

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not appear in the student's top stressors. However, additional qualitative analysis revealed participants experienced a link between relationship satisfaction and perceived stress, suggesting a small impact. This study might be useful in highlighting what trainees perceive to be the benefits of social support. Practical (e.g. financial) and emotional support (e.g. 'venting' and being listened to) was raised as helpful, and supportive of their academic pursuits. However, trainees also experienced relationships as barriers to goals (e.g. when trying to balance obligations to partners and training), which highlights potential adverse effects about social relationships.

Clark et al. (2009) found, of the traditional social support variables, only perceived support from advisors predictive of burnout (not family and friends). However, not all types of support (e.g. spiritual) were assessed. In addition, they claim that individuals being grouped as family/friends may have masked the impact of useful support from specific individuals. However, they argue the advisor relationship might be unique as it involves both support and evaluation. They also found Sense of Community (SOC) directly predicted burnout (and career-choice satisfaction). This fits with general research on college-student burnout (McCarthy, Pretty & Catano, 1990), and Cohen (2004) who argued that psychological functioning is benefited by social integration. Montgomery's (2010) finding discussed earlier similarly highlights how trainees who reported their programs encouraged more supportive environments, stronger peers/staff relationships, and education on relational skills, exhibited less professional stress. Lower burnout was also related to more frequent disclosure of struggles to co-workers (Scarborough, 2009).

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However, Clark et al. (2009) found social support and SOC not significant moderators between stress and burnout despite their direct relationship to burnout. They also argue that perceived support could be accompanied by adverse effects which negate stress-buffering. Townsend (2011) interestingly found the relationship between stress and life-satisfaction unmoderated by social support, but higher life-satisfaction was linked to greater friend/family support and program-related SOC. They note how this fits with Clark et al.'s (2009) finding that social support only moderated career-choice satisfaction when stress was low, which could mean that SOC is not powerful enough to moderate the negative effects of high-perceived stress.

Personality and Coping Styles

Table 5

Studies investigation Personality/Coping Styles and Stress/Burnout

Author(s)/Year	Source	Design	Participants (including type (if reported)/Country)	Predictor variable Measure(s)	Outcome (Burnout / Stress) Measure(s)	Main findings	Moderator
Grigsby, 2016	Dissertation Study	Cross-sectional	67 (America). Clinical = 19 (28.4%) Counseling = 5 (7.5%), Other = 43 (64.1%) (online students)	<i>NEO-FFI-3, CIS</i>	<i>MBI-SS</i> (<i>Ex = Exhaustion, Cy = Cynicism, Ef = Efficacy</i>)	Neuroticism and Ex +++ Neuroticism and Cy +++ Neuroticism and Ef, ns Extraversion and Ex -- Extraversion and Cy -- Extraversion and Ef, ns Openness and Ex, ns Openness and Cy, ns Openness and Ef ++ Agreeableness and Ex, ns Agreeableness and Cy, ns Agreeableness and Ef, ns Conscientiousness and EE -- Conscientiousness and Cy --- Conscientiousness and Ef ++	Avoidance-Oriented coping style moderated Consciousness and burnout
Micheli, 2015	Dissertation Study	Cross-sectional	142 (America). Clinical Psy.D = 85 (60.3%), Clinical =	<i>IRI</i>	<i>CBI</i>	Empathic concern and Burnout -	

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			40 (28.4%) or Counseling = 16) (11.3%) Ph.D			Personal Distress (around emotions of others) and Burnout +
Riise, 2012	Dissertation Study	Cross- sectional	309 (America/Canada). Clinical = 223, Counseling = 74, Other = 12	<i>IPIP, SCOPE</i>	<i>PBI</i>	Openness to New Experiences and Reduced Burnout (scores reversed) - Disengaged Coping Style and Burnout + Engaged Coping Style and Burnout, ns Agreeableness and Burnout, ns Conscientiousness and Burnout, ns Extraversion and Burnout, ns Neuroticism and Burnout, ns
Drake, 2011	Dissertation Study	Cross- sectional	220 traditional and online trainees (America) Ph.D = 170 (77%), Psy.D = 49 (22%), one unidentified	<i>COPE</i>	<i>PSS-14</i>	Positive Coping style and perceived stress - Negative Coping style and perceived stress +++
Myers et al., 2012	Journal Article	Cross- sectional	488 (America) PsyD = 120 (24.6%) PhD = 282 (57.8%) Other = 86 (17.6%)	<i>GLTEQ, MPSS, The Sleep Hygiene Index, ERQ, Mindfulness questionnaire</i>	<i>PSS-14</i>	Stress and: Cognitive reappraisal - Frequent use of suppression -

Personality

Two studies assessed personality based on the 'Big Five' trait model (Costa & McCrea, 1985). Grigsby (2016) found Neuroticism related to higher burnout, and burnout decreased as Extraversion increased. This is consistent with findings that people high in Neuroticism and negative affect (e.g. depression, anxiety, and low self-esteem) are less likely to adapt well to difficult situations in contrast to those with greater hardiness (e.g. believing more in their own control, and having positive outlooks about change), and higher Extraversion with its associated positive emotion (for summary see Brooks et al., 2012).

Riise (2012) found no association between Extraversion and burnout arguing that spending time alone might be as adaptive as being with others during training because this is often required for self-reflection in psychology trainees (Bernard & Goodyear, 2004).

Surprisingly, Riise (2012) found Neuroticism unrelated to burnout, and, Openness to Experience associated with burnout. Riise (2012) notes how Openness has generally been associated with both positive and negative affect (e.g. Bardi & Ryff, 2007), arguably because it amplifies all experiences, regardless of evaluation as good or not. Indeed, Grigsby (2016) did find a positive relationship between Openness to Experience and Professional Efficacy. However, Riise (2012) believed copings styles (discussed below) fully mediated the relationship between Neuroticism, and Openness, on stress/burnout, especially because of the strong relationships they discovered between Openness and well-being, and between Neuroticism and reduced well-being.

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Agreeableness was not associated with burnout across these two studies. Riise (2012) argues agreeableness may be a helpful trait among trainees for creating strong therapeutic alliances with patients. Grigsby (2016) found as Conscientiousness increased burnout decreased, fitting with research that conscientious individuals carefully apply their knowledge/skills to achieve goals, and manage difficult situations (Grant & Langan-Fox, 2006). However, although not associated with burnout, Riise (2012) found it negatively predicted psychological functioning.

In addition, Micheli (2015) found lower dispositional empathy associated with increased burnout, and increased empathy was linked to higher placement satisfaction, which fits with Hall, Davis and Connelly's (2000) finding that qualified psychologists with higher job satisfaction also report higher empathy levels. However, the direction of effect was unclear.

Coping Styles

The findings were consistent with the general literature which shows how 'approach' coping (directly addressing problems) is linked to better overall functioning, while the opposite is true for 'avoidance' coping (e.g. behavioural and cognitive means of not attending to problems) (Steiner, Erickson, Hernandez & Pavelski, 2002). Drake (2011) found a relationship between reduced stress and 'positive coping', which included positive reinterpretation, active planning, and seeking support. 'Negative coping' was associated with increased stress, and included strategies such as behavioural/mental disengagement, denial, focusing on/venting of emotions, and substance-use. Drake (2011) highlight how these findings fit with Nelson, Dell'Oliver, Koch, and Buckler's (2001) research on the usefulness of a variety of coping mechanisms in Clinical Psychology students; while

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positive reappraisal appears useful over many situations, and problem-focused coping is useful in scenarios where solutions can be reached, emotion-focused coping was mixed in terms of effectiveness (and they note has links in the general literature with mental health problems). Similarly, Grigsby (2016) found Emotion-Oriented coping positively correlated with burnout, whereas Task-Oriented coping reduced burnout. Riise (2012) also found Disengaged coping associated with increased burnout, and Grigsby (2016) found that while not directly predictive of burnout, as Avoidant-coping increased, the value of Conscientiousness for Professional Efficacy reduced. However, Myers et al. (2012) found both cognitive re-appraisal, and suppression (inhibition of emotional expression) associated with reduced stress in trainees (this is discussed further later).

Stress Surveys

Four of the studies included stress-surveys which identified stressors before the study and asked participants to rate them in terms of frequency or level of stress. Cushway (1992) found the most frequently rated stressors those which either impacted on practical issues around training such as poor supervision, travelling, finances, and those which were more intrinsic to the work itself, such as managing course deadlines. They note poor supervision in their study was the highest-rated stressor. Kumary and Baker (2008) similarly organised highest rated stressors this way. The greatest practical/organisation issues were around time (e.g. meeting clinical hours, attending placement alongside other commitments), funds, and finding appropriate placements. Those related to the work included academic/research factors (e.g. meeting deadlines, carrying out research) and what they term professional socialisation (e.g. starting placements and supervision).

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Fitting with these findings, El-Ghoroury et al. (2012) noted that academic responsibilities/pressures, finances/debt and poor work/school-life balance were, in addition to general anxiety, among the most common factors identified as problematic to trainees. Cahir and Morris (1991) found by far the largest rated stressor (accounting for over twice the next) was time-constraints. Finally, Bowlin (2014) asked trainees to rate their top three stressors and coded these by frequency, finding by 'school' factors, which included clinical, and academic related stressors, to be the primary source of trainee stress (many stated their top three stressors were all related to this category).

Discussion

Main findings

Overall, the studies highlighted a range of factors associated with stress/burnout in trainee psychologists, which appear helpful for understanding what contributes to elevated stress in this potentially vulnerable population (Pakenham & Stafford-Brown, 2012). Interestingly, studies did not examine stressors specific to training, instead looking at variables known to impact upon stress levels in the general population (e.g. personality traits). The findings here might therefore be limited for an understanding of what unique stressors exist for this group, and excluding qualitative studies which heard trainee's own experiences likely contributed to this. Despite this, the findings highlight what factors might moderate the relationship between the challenges inherent in training and the outcome of stress/burnout. It might also be extrapolated from these results why these factors predict or protect against burnout in the context of the particular academic and clinical demands of training. This will be commented on where apparent. However,

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it is noted that researchers often acknowledged that the specific variable(s) of interest in their study only accounted for a portion of the variance in stress/burnout, and that further research is required to learn what other factors might interact to produce this. Indeed, while the findings were grouped into the themes of personality/coping, well-being/social support, and demographics, there appear many cross-overs between these domains. For example, the capacity to use one's social support networks would be expected to depend on the individual's personality and characteristic coping styles (Riise, 2012).

Demographics. It is noted that for most studies demographic variables were not investigated as a primary aim of the research, but analysed separately, and hence theorising of explanations for findings was limited. Many studies found gender (being female), not being in a relationship, and in later years of training, predictive of stress/burnout. However, gender was unrelated to stress in two studies. As these latter studies were conducted later in time than two of the studies conducted in the early 1990s which found an association, the following suggestions outlined by Montgomery (2010) might account for this. They highlight the changing gender composition of trainings, whereby more women are enrolled now than men (Cynkar, 2007), and argue that perhaps they experience less stress because the psychology field is more inclusive of them, and programmes are more adaptive to their needs (for example in terms of balancing family life with training through flexible options of completing Doctoral programs over longer periods). Alternatively, they argue that men experience increased stress due to changing cultural expectations, such as greater equality in domestic responsibilities, or are now more likely to report stress. Regarding relationships, the findings suggested that having a partner may be a useful buffer against stress but that status (e.g. married or dating) is not important

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(Cushway, 1992). Regarding Year in training, it was argued that Years 2 and 3 might be particularly stressful due to stressors confronted at these times (e.g. starting or finishing the research project, beginning the process of job hunting). Montgomery (2010) highlight that the time data is collected may particularly influence associations between stress and Year in training, because challenges facing students at different stages likely vary throughout the year.

Some studies found higher stress in younger trainees, though for two this was at trend levels. It was speculated that as age increases so does the 'wisdom' for older trainees to manage placements more calmly, and develop more adaptive coping skills, and that subsequently they might experience more well-being if this is responded to well by supervisors. Program type was consistently found not predictive of stress/burnout, suggesting that despite differences in programs, Doctoral psychology trainees experience similar stress levels. Other factors were not widely investigated across studies (e.g. financial stability and job-satisfaction relating to lower stress), but were supported by research with other populations.

It is important to note that other variables may moderate the relationship between simple demographic factors and stress/burnout, which might account for result discrepancies.

Self-care and Social Support. All studies investigating self-care behaviours (e.g. relaxation and sleep hygiene) found in keeping with past research, a range of activities might reduce distress in trainees by promoting mental and physical well-being (Scarborough, 2009). This included self-care interventions being promoted by the trainee's clinical program. Montgomery (2010) argued that the focus of training courses is on developing preparation for professional excellence, and hence it can be

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difficult for trainees to incorporate individual self-care into their schedules alongside the demanding hours required to pass. Indeed, Clinical Psychology trainees have revealed limited time to enjoy life outside of training (Dorff, 1997). Shotwell (2014) commented specifically on trainees needing respite from academic terms, which might explain the usefulness of specific self-care lifestyle factors, such as taking vacations, balancing personal and professional lives, and engaging in creative and personally meaningful activities outside the programme. However, the small relationship found between self-care and stress led Shaw (2013) to propose that to engage in well-being activities could also increase stress; trainees being under academic demands may cause them to feel irresponsible for not attending to these.

Social support revealed mixed findings. While predictive of stress/burnout in three studies, of these, one found only advisor support was significantly related. It was argued that due to involving both support and evaluation, if students do not think they are meeting their advisors' expectations, or are missing guidance, they might become overwhelmed (Clark et al., 2009). Indeed, Cushway's (1992) survey highlighted supervision as the highest-rated stressor, which trainees revealed was due to lack of positive reinforcement and fearing negative evaluation. Hence, a factor unique to trainee psychologists might be that training-related support appears to exert a more powerful influence than help from friends/family. This might be because helpfulness of support often depends on whether it relates to the nature of the stressor (Cohen, 2004). Further, trainees who experienced greater sense of community (SOC) within their programmes, who reported their programmes focused more on fostering a supportive environment, and who more frequently disclosed struggles to co-workers, generally revealed lower stress/burnout. Indeed, external research (Kuyken et al., 2003) shows increased work adjustment in trainee clinical

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psychologists was directly, and indirectly influenced by work-based emotional support (e.g. from supervisors and tutors) via helping trainees feel stressors were manageable, and reducing avoidant-coping.

However, two studies found no statistical association between stress and satisfaction with social or relational support, despite one showing qualitative evidence for a relationship. This was argued to potentially be due to the adverse effects associated with social networks which conflict with their stress-buffering potential, or how a lack of satisfaction in-itself may not directly cause stress but may be a resource when stress occurs. Indeed, Bowlin's (2014) interview method highlighted how trainees valued emotional and practical support from partners, which they felt reduced their stress and facilitated their academic goals. Bowlin (2014) argued that the benefit of this will likely depend on whether the partner can empathise with the challenges (e.g. academic) faced by trainees, and it might also be argued that the confidential nature of clinical work might make accessing emotional support from friends/family difficult. Their findings also highlighted the increased stress arising from attempting to manage obligations at home alongside course demands, which fit with the earlier findings around the difficulties in balancing professional and personal lives. Finally, the discussion revealed that social support might be more conducive to other well-being factors such as career-choice satisfaction in Clinical/Counselling Psychology students.

Personality and Coping Styles. A number of studies found specific personality and coping styles associated with stress/burnout levels in trainee psychologists which is consistent with the literature on psychological functioning in the general population (e.g. Grant & Langan-Fox, 2006, Vollrath & Torgersen, 2000). One study (Grigsby, 2016) discovered trainees with reduced burnout typically

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had greater positive affect and resilience as measured by higher Extraversion, and lower Neuroticism. However, Extraversion not being associated with burnout in another study (Riise, 2012) was argued to be due to this being potentially helpful for this population too, as trainees also need to be able to spend time alone and develop self-reflective skills. Agreeableness and Conscientiousness were both found associated with reduced burnout and argued to be protective traits. This was because these traits might help trainees to establish and maintain strong alliances with patients (and potentially with colleagues), while efficiently attending to important goals during training by dutifully applying the knowledge and skills they develop to achieve these and cope with personal challenges. It is noted that research surrounding goal commitment (Sansone et al., 1999) captures how Conscientiousness can be associated with over-commitment to particular goals at the expense of achieving other goals, which might be relevant as Riise (2012) found it negatively predicted depression and well-being (but not burnout) in trainee psychologists.

Grigsby's (2016) finding that Openness to New Experiences was related to increased Professional Efficacy might be arguably due to it benefitting trainees because of the close relation it has with creativity which has been linked with improved problem-solving and development in school psychologists (Hoff & Buchholz, 1996). However, it has also been associated both with positive and negative affect in other populations (see Riise, 2012 for Summary), potentially because of how individuals approach experiences more fully indiscriminately of its type of affect. This latter point could account for Riise's (2012) finding that there was a slight association between Openness and increased burnout. However, Riise (2012) also found no relationship between Neuroticism and burnout and provided

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evidence that coping strategies were likely to be fully moderating the relationship between these traits and burnout in their study. It is noted that Grisby's (2016) study recruited trainees completing online doctoral programmes which mean their findings might not generalise to those in traditional trainings.

Trainees low in dispositional empathy were more likely to experience burnout (and lower placement satisfaction), although it was unknown if higher empathy protects against burnout, for example through experiencing greater engagement and satisfaction from patient work, or if burnout results in empathy reduction. Stebnicki (2007) proposed that empathy fatigue is likely due to the therapists 'own wounds' (p.318) being revisited by emotionally disturbing material such as loss and trauma, making this another factor which might be particularly unique to trainee psychologists who are often beginning the practice of therapy.

The studies investigating coping strategies suggested that trainees with greater stress/burnout typically coped with challenging situations through disengagement and avoidance, and tended to focus on managing emotional reactions as opposed to changing the situation. These results were fitting with research (Nelson et al., 2001) showing that more successful (in terms of grade-point averages) Clinical Psychology students were likely to employ positive reappraisal and problem-focused coping (the former being useful over many situations and the latter when solutions are possible), as opposed to emotion-focused approaches. However, Myers et al. (2012), commenting on their finding that emotional suppression in trainees was linked to reduced stress, state that while it holds value in temporarily reducing negative affect, this coping strategy is known in other populations to not contribute to long-term wellbeing (Goldin, McRae, Ramel & Gross, 2008).

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Those papers which investigated both personality and coping conceptualised coping as a mediator between personality and psychological functioning, similar to Rutter's (2007) proposal that resilience depends on dynamic processes (e.g. coping strategies) as bridging the gap between stable variables (e.g. personality) and outcomes like stress (Riise, 2012). In line with the transactional theory of coping, Grisby (2016) highlighted how personality traits would first influence the trainee's appraisals of a stressor (e.g. the extent to which it is threatening) and, the coping styles employed would influence the trainee's reaction to it. These findings are supportive of research (Kuyken et al., 2003) on psychological adaptation in Clinical Psychology trainees which found that the consistent use of avoidance-coping was linked to anxiety, depression, self-esteem and work-adjustment problems. Also drawing on the transactional theory of coping, they proposed cognitive appraisals of stressors as threatening and uncontrollable lead to stress not only directly, but via the unhelpful tendency to avoid, and thus reinforce the stressor.

The findings on personality and coping also appear to generally fit with external research showing that trainee psychologists who avoided distress, and were accommodating to as opposed to transforming situations, experienced poorer-work adjustment (Brooks et al., 2012). These researchers stated that the opposite styles appear appropriate for trainees in the human service field. It is noted that they also found that expectations from training accounted for over twice the variance in work-adjustment as personality. However, personality traits were associated with poorer experiences of training which they propose supports prior theory/research (Bandura, 1977; Kobasa, 1979; Lefcourt, 1981) with the general population, on how people with lower resilience and less internal locus of control would be more likely to experience negative responses to unmet expectations.

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Common high-rated stressors (from surveys). It is noted that due to the nature of the stress surveys (from the small number of studies incorporating these), items were pre-determined by the researchers (although piloting with trainees often occurred), except in the case of Bowlin (2014) who asked students to rate their top three stressors. However, common themes were identified from these, which would appear are likely faced by all professional psychology trainees. These included practical issues (such as time-constraints, including difficulty with work/life balance), and the training-specific academic/clinical concerns. As argued by Kumary and Baker (2008), issues relating to practical/organisational factors (such as fitting placements with other commitments) will naturally have an impact on the stress trainees feel in a variety of areas in their lives, especially in the context of their personal obligations outside of the programme. In addition, stress would also naturally be encountered about the intrinsic academic/clinical aspects of post-graduate training, such as meeting the requirements to pass the course (including the research project) and placements. Poor supervision was noted as particularly stressful by Cushway (1992), which additional comments from trainees revealed to be due to criticism and lack of positive feedback/encouragement, which again highlights the significance of evaluation to trainees. Given the great responsibilities on students in terms of placement work, academia, and home-life found by Cahir and Morris (1991), they state that it is not surprising time-constraints were rated the most significant stressor.

Implications

As was highlighted, many variables associated with stress found in this review (particularly personality, coping styles and work-related support) fit with research highlighting their negative impact on work-adaption in trainee Clinical

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Psychologists (Brooks et al., 2012; Kuyken et al., 2003). This strengthens the likelihood that the findings outlined above might have detrimental consequences for the quality of care offered to service-users, as well as the professional well-being of trainees. The positive associations found in past research between compassion fatigue and burnout (Mol et al., 2015) might also suggest that the findings play a role in the development of this related concept, thus also potentially disrupting the relationship between service-user and professional. It therefore seems important that training programmes are aware of how these factors might predict or protect against increased stress, so that potential stress-related impairment is mitigated. This might contribute to the resilience of psychologists practicing in high-pressured and resource-limited services where NHS mental health staff report high levels of stress and burnout (Rao et al, 2016).

Myers et al (2012) remind that engagement in adequate self-care is acknowledged as a core competence in clinical training (Rodolfa, Bent, Eisman, Nelson, Rehm & Ritchie, 2005), and the promotion of this can be considered a 'preventative model' which provides a foundation for long-term professionalism (Elman, Illfelder-Kaye & Robiner, 2005). However, Montgomery (2010) found 64% of students did not believe their program adequately addressed their well-being, and 82% desired greater effort in this area. Given the associations found between self-care, supportive programme environments and reduced burnout, there are numerous ways courses might facilitate trainee well-being. Programmes could provide more education on stress-related impairment while promoting the value of self-care, for example through academic lectures/assignments. In addition, an evaluation of workload demands on students could help ensure these do not impede their capacity to maintain a work-life balance. To create greater psychological sense of community,

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programmes could schedule frequent social events within the academic timetable, encourage students to be involved in special interest groups, promote a 'buddy system', and arrange regular trainee-staff meetings (Clark et al., 2009; Shotwell, 2014). Due to the particular influence of advisor support on burnout, the importance of this relationship might be given special attention by programmes, and might be a useful area to intervene with trainees experiencing stress (e.g. via additional emotional support/practical guidance). The tutor can also assess how integrated trainees are within the program culture. Myers et al. (2012) state the importance of promoting specific behaviours which demonstrate efficacy for reducing stress, and not vague concepts of self-care. For example, Mindfulness-Based interventions reduced distress in trainee Counselling Psychologists (Shapiro, Brown & Biegel, 2007).

The associations found between personality, coping styles and burnout, mean the characteristics of individual trainees might be useful for their programmes to be aware of. This might help to predict difficulties on training, or help trainees to better manage stressors with greater effectiveness (Riise, 2012). For example, a trainee who notices themselves excessively worrying about passing academic requirements might find it useful to be made aware of the potential for individuals with particular traits (e.g. neurotic) to respond worse to stressors due to overly threatening interpretations. Similarly, a trainee identified as avoidant-oriented in their coping may be assisted to target problems more directly where a solution to a distressing clinical scenario might be attained. This information might be explored within mentoring and supervisory relationships which Bernard and Goodyear (2004) highlight aid the process of learning and approaching situations differently. Riise (2012) also argues that psychology trainees are possibly unique due to their

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developing knowledge about stress-management, psychological functioning, and personality, and presumably have relative insight into their own characteristics and coping resources. Brooks, Holttum and Lavender (2012) state that findings on the negative consequences of inherent and stable traits may imply the benefit of using personality measures to aid training selection, although feel this premature without greater understanding of the mechanisms in the relationship between work-related impairment and personality. Indeed, causality cannot be assumed due to the cross-sectional design of the studies. Micheli (2015) also calls for programmes to pay attention to placement satisfaction of students' due to its connection with empathy levels and burnout, although similarly acknowledge the need to explore what other variables moderate these relationships.

Due to the discussed potential of interaction effects between the themes identified in this review, it may be useful for programmes to be aware of trainees who possess multiple factors which might put them at risk (for example, avoidant-coping strategies, absence of social support, and belonging to certain demographic groups such as being a younger student). Papers examining the highest-rated/most frequent sources of stress, captured how trainees will have a naturally unavoidable confrontation with at least one, but likely more, of the top stressors related to practical/organisational issues (e.g. time, finances), and the academic/clinical components of post-graduate training. Being aware of the risk and protective factors highlighted in this review might contribute to creating individualised support programs which target a trainee's specific needs. This might occur during regular work-related appraisals or through the personal tutor.

Limitations Summary

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The cross-sectional design of the studies meant that caution must be taken with inferring causality. Stress can also fluctuate throughout the academic year (e.g. in teaching terms, clinical schedule, and research involvement) and so experiences at the point of data collection may have been significant confounding variables. Due to convenience sampling, participants may have differed in important ways across studies from the norm trainee population. For example, studies investigating self-care could have attracted more trainees who engaged in self-care activities regularly, and consequently experienced lower stress. Trainees who dropped-out from, or failed their programmes, were unable to participate, which might have removed potential of examining stress predictors for those who experienced levels to the point of greater impairment. Finally, while Montgomery (2010), in defence of self-report stress items, argued that what is important is the trainees own experiences of stress, it is possible trainees might be particularly conscious of wanting to appear as competent practitioners, and because of social-desirability bias (Orne, 1962), report they are managing stress/burnout well.

More significantly, as noted, the potential difference between accredited and non-accredited training programmes (with around half of the papers not acknowledging this status) could have meant the groups examined across studies were not comparable.

Future Research

Future research in this field could benefit from longitudinal, repeated-measure designs to more fully understand the relationships between stress and predictor variables, including the impact of these other time. To overcome self-report unreliability and bias, stress and its effects can now be investigated in a variety of

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ways, including indirectly via workforce absenteeism, and also via more technologically advanced methods such as biochemical markers, which future research could make use of (Hannigan et al, 2016).

As discussed, interaction effects between factors (e.g. between personality and self-care) may offer a more complete picture of what leads to burnout in trainee psychologists, and studies rarely examined how factors might be moderated by other variables. Future research could investigate this using the domains highlighted by this review as a template for exploring interactions between a range of predictor variables and stress outcomes in trainee psychologists. Further, a number of studies (e.g. Montgomery, 2010) note that there are other course-related factors which may contribute to variance in stress/burnout, such as trainee to staff ratios, teaching environment and resources, and quality of placement. It is therefore important to assess wider programme variables which may impact trainee well-being.

As noted, studies rarely investigated factors which might be specific to stress in trainees (and not the general population). While this review focused on quantitative studies, it might be useful for research to utilise mixed-methods approaches as did Bowlin (2014), to learn from trainees themselves why these factors were perceived as important in the context of the challenges they face.

Finally, as more research becomes available, a review might benefit from the inclusion of more peer-reviewed articles to ensure methodological rigour of a high standard. This would include detailed information about the trainee samples being studied (e.g. accreditation status of programme, and clinical practice requirements of non-accredited programmes) which would help determine if the participants are from comparable courses.

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Part Two: Empirical Paper

Trainee Therapist Goal Conflict and its Relationship to Perceptions of Goal attainment and Occupational Stress

Abstract

Aims: Therapist goals likely emerge from competency frameworks and also personal values and interests, which might not be consistent with each other. Research provides substantial evidence of associations between goal conflicts, reduced psychological well-being, and goal success. If goal conflict is a factor negatively influencing therapist well-being, it could also impede their delivery of high quality care. This study aims to explore these possibilities.

Method: The study recruited 52 trainee Clinical Psychologists. A semi-structured interview was employed to identify therapists' goals followed by a goal conflict matrix. The Maslach Burnout Inventory was used to measure occupational stress. Therapist goals were also coded as 'lower-order' (more concrete 'doing' goals), or 'higher-order' (more abstract 'being' goals), based on a commonly used goal characteristic framework.

Results: Significant associations were found between higher-order goal facilitation and increased Professional Accomplishment, and, between increased goal ambivalence and perceived difficulty attaining goals. Consistent with the literature, findings were understood within a hierarchical model of goal conflict, whereby conflicts at higher levels are most detrimental to well-being.

Conclusion: The findings suggest that when psychologists experience conflict between their more abstract motives, values and needs, they are likely to experience burnout. And when experiencing mixed motivations about goals, are more likely to experience difficulty attaining them. The implications that targeting goal conflicts may be conducive to the professional well-being and potential effectiveness of clinicians are discussed. However, the study was underpowered, and some findings were only found significant at $p < .05$, requiring caution when interpreting.

Introduction

Burnout is a form of chronic work-related stress, and has been found associated with a range of negative outcomes, for example reduced affective well-being, impaired occupational functioning, protracted sick-leave, ill-health and workforce turnover (Jenaro et al., 2007; Ruotsalainen, Verbeek, Mariné & Serra, 2014; Sutherland & Cooper, 1990). It can feature emotional exhaustion, depersonalisation and lack of personal efficacy or accomplishment (Maslach & Goldberg, 1998; Pakenham & Stafford-Brown, 2012). Burnout has been noted to be especially high amongst those in the human-services and caring professions, who are at risk of elevated stress (Jenaro et al., 2007; Weiss, 2004).

Amongst health care professionals, Clinical Psychologists may have especially heightened risk of burnout due to both the context and content of their work (Grigsby, 2016). For example, psychologists are working in isolated and resource-limited environments, confronted by emotionally-challenging and sometimes traumatic material (Anagnostopoulos & Niakas, 2010; Grant & Campbell, 2007; Jenaro et al., 2007; Linley & Joseph, 2007). A recent review of studies of stress in UK Clinical Psychologists highlighted that commonly-identified stressors, including patient characteristics (such as feelings of worry or irritation towards service-users), high workloads, professional self-doubt, and poor quality of service management, contributed to high stress (Hannigan, Edwards & Burnard, 2016). This finding suggests that this population typically find their work demanding and stressful, with as many as 40% of Clinical Psychologists reporting 'caseness' levels of distress, and in particular indicating high-levels of emotional exhaustion. Further, evidence has shown that psychologists themselves recognize that stress-related impairment in work can cause potential harm to patients (Smith & Moss,

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2009). For example, 37% of psychologists experiencing distress felt this lowered the quality of their work, with 5% suggesting this led to inadequate practice (Guy, Poelstra & Stark, 1989).

Evidence has shown that role conflict and ambiguity are associated with greater burnout in mental health workers (Acker, 2003). A review of studies investigating nurses transitioning from direct care to management revealed strong evidence of perceived role conflict and ambiguity (Smith, 2011). Role conflict was understood to arise from multiple job demands that the individual perceives to be incompatible, while ambiguity refers to uncertainty about expected behaviours and consequent action. Role conflict and ambiguity's contribution towards burnout and stress can be understood relative to an accumulation of evidence which identifies the locus of the conflict as more clearly between goals. Goal conflict can be defined as arising when an attempt to achieve one goal interferes with the attainment of another (Segerstrom & Solberg Nes, 2006). In this context, research has provided substantial evidence of the associations between goal conflict and reduced psychological and physical well-being, perception of goal progress and likelihood of goal success (Kelly, Mansell & Wood, 2015). Regarding burnout, Pomaki, Maes, and ter Doest (2004), found that as goal conflict increased, so did Emotional Exhaustion in health-care employees.

One study found 75% of 287 UK-based trainee Clinical Psychologists reported moderate or high-stress from training (Cushway, 1992). The literature review highlighted a range of variables (e.g. coping strategies, self-care behaviours and social support) influencing stress/burnout in this group, which awareness of appear useful for mitigating elevated stress. However, no studies explored the potential role of goal conflict. While Beck (2011) highlighted the relevance of client

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goals as central to most therapeutic interventions (particularly CBT), it is surprising that little attention has been given to therapists' goals.

Psychology training has been highlighted to be a formative period where students can learn skills for later effective professional functioning (Kuyken et al., 2003). As goal conflict can also be an opportunity for personal growth and development (Brim & Kagan, 1980), knowing if goal conflict predicts burnout at this crucial stage in training could help trainees and supervisors to capitalise on this. This could help foster healthier and potentially more effective clinicians, throughout their careers. The current proposal aims to explore these possibilities.

Overview of Goal Conflict Research

The striving for and achievement of goals has been widely found related to well-being and fulfilment, playing a significant role in identity, organisation of activities, and meaning in people's lives (Gray, Ozer & Rosenthal, 2017). However, problems can arise when goals come into conflict. Because not all goals can be actively pursued at once, some goals must be engaged at the cost of other goals (Segerstrom & Solberg Nes, 2006). Kehr (2003) states that it is widely recognised that goal conflict affects the likelihood of goal success; it can cause unhelpful rumination, inhibit the individuals' capacity to approach, and ultimately prevent them progressing with their goals (Boudreaux & Ozer, 2013; Cantor, Acker & Cook-Flannagan, 1992; Kleiman & Hassin, 2011). As an example, long-term smokers were less likely to succeed in quitting when the goal to stop conflicted with other powerful personal aims (McKeeman & Karoly, 1991). Riediger (2007) notes that goals may undermine one another in one situation but facilitate each other in a different situation. Hence, the cause of conflict may be more inherent to the individual or based on external factors (Segerstrom & Solberg Nes, 2006).

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Kelly et al. (2015) found that 78 of the 83 studies which were included in their review of goal conflict research showed correlations or predictive relationships between various forms of goal conflict and well-being outcomes. To summarise the encompassing disruptive effects of goal conflict, they found increased psychological symptoms (including anxiety, depression and negative affectivity), poorer outcomes on a variety of subjective psychological health measures (such as lowered life satisfaction and self-esteem), and problematic outcomes within professional settings (e.g. burnout). Physical well-being was also negatively impacted. In addition, the perceived probability of achieving goals, and actual goal progress was hindered.

Hierarchical Model of Conflict

Goal conflict can be understood within a general framework whereby goals are conceptualised as hierarchical networks (Austin & Vancouver, 1996). It is proposed (Watkins, 2011; Carver & Scheier, 1982; Kelly et al., 2015) that effective self-regulation occurs when lower level concrete, practical goals help achieve goals at higher, more abstract levels (which correspond to the individual's fundamental values and motivations). 'Goal conflict' is understood as happening from this theoretical viewpoint at the lower levels when competition for the same resources (e.g. time) occurs to achieve higher level goals (e.g. to spend more hours working, or to spend more time with friends). Kelly et al. (2015) note that integrating research in the field of goal conflict has been unclear due to the different vocabularies, assessment methods and theoretical underpinnings used, with no distinction of form of conflict. Reviewing the literature, and integrating four domains of research, they propose evidence for a hierarchical model of goal conflict (see Figure 1). Kelly et al. (2015) found that conflicts between goals pursued in the course of everyday behaviour (short-term, lower level goals) were associated with weaker detriment to

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well-being as compared to conflicts at multiple levels or higher up the hierarchy (discussed next).

Goal ambivalence is often defined in research as when one both wants and does not want (believing they would not be entirely happy) to attain that goal. This can be considered an approach-avoidance conflict (Sincoff, 1990), or, as Emmons & King (1988) describe, a within-striving conflict. Ambivalence towards goals is usually measured by one item taken from Emmon's (1986) Strivings Assessment Scale (SAS) which examined a variety of properties the individual perceives about their goals. The question asks how '*unhappy*' the person would be if they succeeded in achieving the goal, assuming that unhappiness about being successful in that striving represents ambivalence about moving towards it. Within their model, Kelly et al. (2015) propose that "Ambivalence about pursuing low level goals is conceptualised as conflict between the goals or motives at the level above" (p.213). Therefore, the experience of ambivalence is an expression of mid-level conflict, which they argue concern 'being goals'. An example of conflict at this level is between "being a good parent" and "being successful in my career". The expression of the conflict might then be in the feeling that one is not spending enough time with their family while they are at work (a lower, more concrete goal).

High level conflicts were associated with more fundamental self-discrepancies. These are often investigated via exploring abstract and self-definitional abstract statements regarding what an individual wants or feels they should be, then examining inconsistencies between their 'actual', 'ideal', and 'ought' selves (Higgins, 1997). Emmons (1992) argued that higher level conflict results in

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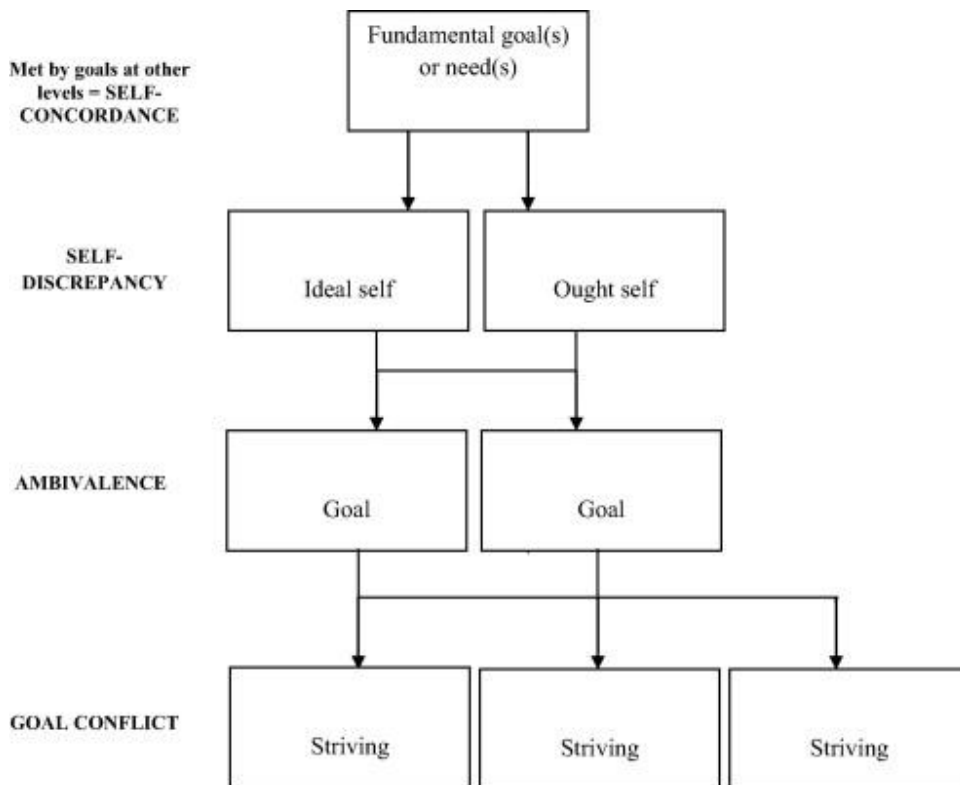
greater disruptive consequences due to the goals being more intrapsychic and self-definitional.

Finally, Sheldon and Kasser (1995) initially distinguished how goal coherence refers to the way a person's goals interact with one another, while goal concordance refers to their connection to one's organismic needs. They found people experienced greater well-being from attaining concordant goals, as opposed to little change when fulfilling non-concordant goals. However, unlike Sheldon and Kasser (1995), Kelly et al. (2015) do not argue that the pursuit of externally motivated goals necessitates conflict, just that conflict may exist between intrinsic and external goals. Goal concordance is thus conceptualised as this quality of the goal hierarchy; when goals at other levels fulfil a person's "intrinsic needs and fundamental values" (p.214).

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Figure 1

Hierarchical model of conflict



Note. Reprinted from "Goal conflict and well-being: A review and hierarchical model of goal conflict, ambivalence, self-discrepancy and self-concordance", by Kelly, R. E., Mansell, W., & Wood, A. M., 2015, *Personality and Individual Differences*, 85, p.213. Copyright 2015 by Elsevier.

Investigating Conflict

Conflict arising from the pursuit of one goal impeding the successful attainment of another is typically measured via matrix-based assessments. One common method is Emmons and King's (1988) Striving Instrumentality Matrix (SIM). In their seminal study, participants were asked to write down 15 goals, defined as 'an objective you are trying to accomplish or attain'. Each goal was compared to another by the participant scoring if achieving one striving has a 'helpful', 'harmful', or 'no' effect, on their other strivings. The conflict score each goal has was then calculated, as well as a participant's overall goal conflict score. Scores in the positive range of the scale are said to capture goal integration or facilitation, whereas those in the negative range reflect goal conflict or interference (Kelly et al., 2015; Riediger & Freund, 2004). This tool for investigating conflict has shown across many studies (Cox & Klinger, 2011; Kelly et al., 2015) the negative impact of goal conflict on well-being, as well as goal motivation and attainment. While the SIM itself does not discriminate level of conflict, Wallenius' (2000) coding framework offers a means of retrospectively categorising goals as broadly either lower level ('doing' goals) or higher level ('being' goals).

Therapist Goals

For therapists, lower level goals could be expected to relate to within session strivings (e.g. to listen to the client) which serve to pursue their mid-level 'being goals' (e.g. to be an empathic therapist) and higher level 'self' goals (e.g. 'to be a kind human being'). One source for therapist goals are the competencies that are mandated by assurance bodies for the provision of quality therapy. An example of such a competency may be the ability to adhere to an agreed session agenda. The

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CBT competency maps (Roth & Pilling, 2007) include a number of general competencies, basic modality-specific competencies, modality specific techniques, problem specific adaptations, and meta-competencies. In parallel with this, therapists have idiosyncratic goals based on personal values, standards and interests that exist outside of the formal frameworks. It is possible that therapists perceive conflicts between these personal goals and the requirements of external guidelines. An example of this type of conflict might be that a therapist might feel it is very important to listen and never interrupt someone who is in distress (a personal goal) but feel this is conflicting with setting a session agenda (a goal relevant to the model they are using).

Associations between a patient's goals conflicts in therapy and their engagement in the treatment have highlighted the importance of goal conflict in the therapeutic setting. Michalak and Shulte (2002) used the SIM with a sample of 55 outpatients with anxiety disorder and found patients' total conflict scores and the conflict score associated with the specific goal to gain 'relief from symptoms' were highly correlated with patient motivations, which in turn were also correlated with treatment outcomes. However, while explored with patients, goal conflicts in therapists have not been investigated to date. Such goal conflicts could play a role in therapist wellbeing and goal progression. If goal conflict is a factor influencing burnout, it could, as noted earlier, impede their ability to provide high quality care.

Research Questions

Hypothesis 1. As ambivalence increases, therapists will report increased burnout (as defined by Mashlach's Burnout Inventory), and greater perceived difficulty attaining goals.

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Based on the aforementioned research, it is predicted that there will be a positive correlation between ambivalence and burnout. As goal ambivalence increases, Personal Accomplishment is expected to decrease, while Emotional Exhaustion and Depersonalisation will increase. There will also be a negative correlation between goal ambivalence and perceived goal attainment.

Hypothesis 2a. As mean goal interference increases, therapists will report increased burnout (as defined by Mashlach's Burnout Inventory), and greater perceived difficulty attaining goals.

Based on aforementioned research, it is predicted that there will be a negative correlation between goal interference (conflict) and well-being. As goal interference increases, Personal Accomplishment is expected to decrease, while Emotional Exhaustion and Depersonalisation will increase. There will also be a negative correlation between goal interference and perceived goal attainment.

Hypothesis 2b. Higher level conflict will be more strongly associated with greater burnout and reduced goal progression when compared to lower level conflict.

Based on past findings, interference higher in a participant's goal hierarchy should be more detrimental to well-being and goal progression.

Method

Design

The research used a cross-sectional design. Participant data was gathered from three measures. The goal interview was completed together with the participant, while their goal matrix and the burnout measure were delivered via E-Mail. This was done because the researcher created an individual matrix for participants based on their idiosyncratic goals. It was most efficient for participants

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to complete this later rather than waiting for it to be prepared.

Procedure and Participants

To begin the process of recruiting Trainee Clinical Psychologists as participants, an E-Mail was sent to all London-based training programmes. This requested the courses to circulate a recruitment E-Mail to their training cohorts (both E-Mails are shown in Appendix B). An information sheet (Appendix C) about the study was attached, outlining the following entry criteria:

- Trainee Clinical Psychologists will be undertaking a Doctorate in Clinical Psychology.
- They will be required to have already completed a six-month placement where they have had clinical experience offering psychological therapy within the last six months.
- They must be fluent in understanding English in order to follow the verbal and written instructions.

Potential participants interested in taking part, or wishing to ask questions, were encouraged to contact the researcher via the E-Mail provided on the Information Sheet. The researcher then arranged a meeting place/time (including over telephone) to deliver the goal interview. Following this, participants completed the rating of the matrix, and the burnout measure in their own time, which was sent to them and returned via E-Mail. Consent forms were completed either in person or electronically. In total, 52 interviews with participants were performed (a mixture of 47 via telephone and five face-to-face), lasting on average 30 minutes.

Measures

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Striving Instrumentality Matrix (SIM; Emmons and King, 1988). The basic structure of the SIM (Emmons & King, 1988), as described in the introduction, was used to generate goals, although with slight modifications which are justified below.

The standard SIM instructions when asking participants to identify their goals were amended to identify goals pertaining to clinical roles rather than in their everyday lives outside of work (See Appendix E for Procedural Instructions). To reduce the potential pressure of asking participants to elicit goals in a particular hypothetical situation (which might interfere with their ability to generate authentic goals), they were given the choice to imagine any clinical-related scenario they wished. Participants were told that goals might be around what they are trying to accomplish during therapy sessions or more widely in their service. It was explained that a goal might be important on a personal level, or important to achieve in the service where they work. Two examples of goals were given to all participants; "I want to show the client I am interested in helping them", or "I need to check for client risk each week". Prompts (see Appendix E) were also provided if a participant appeared to be struggling, offering a number of scenarios to choose from to facilitate their awareness of their goals, for example by asking them to imagine a 'typical' first session with a new referral. Research using the SIM typically asks for between 10-15 goals.

An example conflict matrix sheet with instructions given to participants is shown in Appendix F. The researcher calculated an overall goal conflict score for the matrix by examining the mean of all goal pair ratings which the participant scored in their own time after the interview. The higher the number, the more this indicated

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inter-goal facilitation. A conflict score for each individual goal was also calculated by averaging the ratings for the row and column containing this goal. The SIM was found to have a split-test reliability coefficient of $r = .91$, and a 1-year test–retest reliability of $r = .58$ (Emmons & King, 1988).

Striving Assessment Scale (SAS, Emmons, 1986). For each goal generated, a rating was also taken for the ambivalence felt towards, and the difficulty perceived around attaining it. Both goal dimension questions were single items taken from the SAS and rated on a 5-point scale, with 0 as ‘not at all’, to 5 as ‘extremely’. The remaining goal dimensions in the SAS were not used as they did not pertain to the hypotheses of the current study. However, the standard instructions were modified; if participants indicated difficulty around attaining a goal (e.g. scoring above ‘0’), they were asked "Could you say more about why progressing with that goal is difficult?". Their response to this was used to help them identify if another of their goals (which might be in conflict but not in immediate awareness) was undermining this goal. For example, if the participant stated that the goal 'allowing the client to tell their story' was not progressing well because they needed to spend significant time in the session planning a homework task, the participant was then helped to frame this as another important session objective; 'to set homework'. Following this, or if they revealed no issues progressing with the goal, they were asked to proceed to stating their next goal.

Goal Level Coding. The goals were retrospectively coded using Wallenius' (2000) framework as ‘lower’, or ‘higher’ order. Examples of lower-order goals included ‘to administer outcome measures every session’, ‘to formulate the client’s presenting problem using a theoretical model’, and ‘to reduce the client’s

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psychological symptoms'. Examples of higher-order goals included 'to maintain personal integrity as a therapist by speaking up when I disagree with the team', 'to feel a sense of achievement by making a difference to the lives of clients', and 'to be liked by my supervisor'. Twenty goals from all participants were randomly selected by the primary researcher and sent to the academic researcher. Both coded the goals and then discussed ratings. During this process, it was agreed how particular goals which could be coded as both lower and higher-order would be decided upon, for example, goals around the therapeutic alliance would be in the former category as they appeared concerned with behavioural-based competency strivings as opposed to more abstract relational values. At the end of this, each researcher coded another randomly selected 30 goals (different from those previously rated). At this stage, inter-rated agreement was considered 'substantial' (Landis & Koch, 1977) at $Kappa = .64, p < 0.001$.

Maslach Burnout Inventory - Human Services Survey (MBI-HSS, Maslach & Jackson, 1981). The Maslach Burnout Inventory (MBI) is the most frequently employed burnout measure, regardless of occupation or source of stress (Maslach, Schaufeli & Leiter, 2001). The MBI-HSS has been designed for professionals in the human services. The three-factor structure has been found to be applicable across occupations and national contexts (Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998). Its sub-scale questions specifically address Personal Accomplishment (e.g. 'I deal very effectively with the problems of my patients'), Emotional Exhaustion (e.g. 'I feel emotionally drained from my work') and Depersonalisation (e.g. 'I don't really care what happens to some patients') in relation to the respondent's work. Items are rated on a 7-point scale ranging from 'every day'

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to 'never'.

Ethical Considerations

Ethical approval was granted for the study (UCL Ethics Project ID Number: 4901/001, Appendix G). As the study was investigating work-related conflict, this might naturally arouse distress. However, this was not expected to be any more distress than the therapist would encounter in their daily practice. However, participants could interpret the purpose of this study as a measure of their competence. As trainees, they might be sensitive to concerns about their performance and feel anxiety, embarrassment, and shame, especially if they feel that the researcher is judging them. To help participants feel safe, it was made clear that this is an exploratory study and that there are no expectations, standards or “right” answers. During debriefing, it was normalised that it is not uncommon for one's goals to conflict, and that if they did, this does not reflect on the participants' quality as a practitioner. It is noted that no participant reported distress during or after the interview, nor withdrew their participation.

Analysis

Due to the dependent variable of burnout being at the level of the individual and not in relation to particular goals, mean goal ratings were calculated for each individual, and compared to burnout scores. These goal ratings included mean conflict, ambivalence, and difficulty attaining. Because difficulty could be calculated at the average (individual participant) level, and at the individual goal level, it could be both compared with specific goal and average conflict/ambivalence scores. Comparing at the goal level within individuals was achieved by conducting Fishers r to z transformations and testing the resultant average correlations.

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The level of burnout for the sample was also calculated based on Maslach and Jackson's (1986) cut-off scores. It is noted that this measure does not provide an overall burnout score, and that scores for Personal Accomplishment are interpreted in the opposite direction to the other sub-scales, meaning low scores indicate high levels of burnout.

Examining the data, the variables were not skewed and so could be analysed with Pearson correlation coefficients. Two-tailed tests of significance were used to explore the possibility of associations in both directions.

Power

Gray, Ozer and Rosenthal's (2017) meta-analysis of goal conflict studies found that the median weighted effect size of goal conflict on negative psychological functioning was $r = 0.34$. It was initially aimed to use a two-tailed $p < .01$ (at 80% power) with estimate at .4 requiring 68 participants (Cohen, 1988). However, the final sample ($n = 52$) fell short of this. As will be discussed, findings significant at $p < .05$ should be treated with caution.

Results

The age of participants ranged from 26 to 47. Participants were 40 women and 12 men.

Participants produced between 10 and 14 goals ($Mdn = 11$). The mean goal conflict score across participants was 0.77 ($SD = .44$) ($t(51) = 12.67, p = < .001$), which suggests that on average participant goals were more helpful to one another than unhelpful. The mean ambivalence score was 0.83 ($SD = 0.48$) ($t(51) = 12.51, p = < .001$), which suggests that low ambivalence as opposed to high ambivalence was experienced on average towards goals.

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A Wilcoxon Signed-ranks test highlighted that participants generated more lower-order (Mdn = 9) than higher-order (Mdn = 1) goals ($z = 6.29, p < .001$). It is noted that ten of 52 participants had no higher-order goals. Furthermore, where participants had only one higher goal (17 of 52), no conflict score could be generated.

The majority of the sample were in the low and moderate range for Emotional Exhaustion, low range for Depersonalisation, and moderate range for Personal Accomplishment (see Table 1).

Table 1
Level of Burnout for Sample (n = 52)

	Low (%)	Mod (%)	High (%)
Emotional Exhaustion	22 (42)	18 (35)	12 (23)
Depersonalization	43 (83)	7 (13)	2 (4)
Personal Accomplishment	17 (33)	28 (54)	7 (13)

Hypothesis 1. When examined at the group level, there were no significant correlations between mean ambivalence and the burnout domains, nor between mean ambivalence and difficulty attaining goals (see Table 2).

Table 2
Correlations between Goal Ambivalence/ Difficulty Means and Burnout

	Difficulty	EE	DP	PA
Ambivalence	.197	.102	.113	-.045
Difficulty		.208	.141	-.042

* $p < .05$

Goal ambivalence and difficulty were then correlated within individuals, and a one-sample T-Test was performed on each participant's correlation co-efficient. A Fisher r to z transformation was performed as the average r is an underestimate of

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the effect (Silver & Dunlap, 1987). Across the sample, the z scores were greater than zero ($M = .32$, $SD = .47$) ($t(51) = 4.93$, $p < .001$).

Hypothesis 2a. When examined at the group level, there were no significant correlations between mean goal conflict and burnout, nor between mean goal conflict and difficulty attaining goals (see Table 3).

Table 3
Correlations between Goal Conflict/Difficulty Means and Burnout

Mean	Difficulty	EE	DP	PA
Conflict	-.212	-.189	-.129	-.136
Difficulty		.208	.141	-.042

* $p < .05$

Goal conflict and difficulty were then correlated within individuals, and a one-sample T-Test was performed on each participant's correlation co-efficient, again using a Fisher r to z transformation. No significant differences were found between goal conflict and difficulty attaining goals ($M = .07$, $SD = .37$) ($t(51) = -1.39$, ns.)

Hypothesis 2b. Correlations were firstly explored between lower and higher-order conflict means (only within each level respectively), burnout, and goal difficulty (see Table 4). As the conflict means for lower and higher-order goals were not normally distributed, a non-parametric (Spearman) test was used. There was a significant positive correlation between higher-order facilitation and Personal Accomplishment. This meant that as conflict reduced, Personal Accomplishment increased. There were no other significant relationships between mean conflict at the level of goal abstraction, and burnout/difficulty attaining goals. The number of higher-order goals reported across the sample meant there were insufficient data for correlational analyses.

Table 4

Correlations between Goal Level Conflict Means and Burnout

	Difficulty	EE	DP	PA
Low-Level Conflict Mean	-.229	-.148	-.127	-.161
High-Level Conflict Mean	-.033	-.061	-.199	.426*

* $p < .05$

The difference between lower and higher-order conflict correlations (for Professional Accomplishment) was then tested using Steiger's Z, which showed significant difference ($z = -3.30, p < .001$).

Discussion

The findings will be contextualised in relation to the available theoretical literature and research on goal conflict. It is noted that power was restricted by the pool of available participants which will be commented on further, along with several design limitations which may offer an alternative interpretation of the results.

Main Findings

Hypothesis 1. The results partially supported hypothesis 1. Greater ambivalence was associated with increased perceived difficulty attaining goals, but only when analysed within (and not across) individuals. The finding that participants with higher ambivalence overall was not associated with difficulty attaining goals demonstrates how its negative effect on goal progression needs to be understood within an individual's goals. This is because correlating averages underestimates the average of correlations (Monin & Oppenheimer, 2005), and so by averaging goal ratings the individual's judgement of their own goals are obscured. Within Kelly et al.'s (2015) model, it is argued that ambivalence felt about strivings is likely an expression of conflict between higher level motives. So, a trainee who felt ambivalence (expression of conflict) about the goal to 'complete intervention with a

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client within 12 sessions' may experience this because they are being motivated to pursue opposing goals (the cause of the conflict) higher in their personal goal hierarchy. These higher-level goals might be 'to be a good trainee by adhering to service commissioning session number guidelines', and 'to be a good therapist by continuing to see clients until significant symptom reduction is reached'. Being driven by motives in both directions would be expected to inhibit movement towards ending within 12 sessions if symptom reduction is not reached (and result in them feeling a certain level of unhappiness even if they were to progress with that goal). This finding was therefore consistent with the general literature that goal conflict is associated with inhibited and reduced goal attainment (Emmons & King, 1988; Kehr, 2003; McKeeman & Karoly, 1991). However, that ambivalence was not associated with burnout conflicts with past findings on its relationship with well-being (Kelly et al., 2015).

Hypotheses 2a. The analysis did not support hypothesis 2a. Mean level of goal interference was not associated with burnout nor difficulty attaining goals. Prior the current research, the question of the role of goal conflict for adverse outcomes for training therapists had not been addressed, and this finding conflicted with many past goal conflict studies highlighting the impact of conflict across students and a variety of clinical and healthy adult samples (e.g. Kehr, 2003; Kelly et al., 2015). However, Kelly et al. (2015) cite evidence that the negative impact of goal conflict was weakest in those studies employing matrix-based measures of conflict such as the SIM. Limitations of this measure will be returned to later.

One major difference was that studies included in Kelly et al.'s (2015) review employed a variety of subjective well-being measures examining positive and negative affectivity (including depression, life satisfaction and general psychological

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and physical health). Interestingly, Montgomery (2010), exploring self-care factors predictive of trainee psychologist burnout, found these sometimes associated with personal stress but unrelated to professional stress. Therefore, it is possible that while goal interference negatively affected the personal well-being of participants, it did not extend to professional burnout as measured in this study. However, this conflicts with Pomaki, Maes, and ter Doest's (2004) finding that when goals conflicted, health-care workers typically reported Emotional Exhaustion.

However, the result would also be expected in the context of the hierarchical model of goal conflict (Kelly et al., 2015). As noted in the introduction, conflict can exist at a variety of levels, and the SIM used in this study does not take goal level into account. It generally measures low level conflict as it records what the person's behaviour is striving to do on any given day. Kelly et al. (2015) note that while Emmons and King (1988) evidenced an association between conflict and distress, the participants in the study seemed to produce more high level goals. Also using the SIM, Romero, Villar, Luengo, and Gomez-Fraguela (2009) found low level conflict not linked to well-being. In addition, using matrix-based approach, Wallenius (2000) noted more conflict and distress around higher-order goals. Therefore, if the relationship between conflict and burnout/goal progression is determined by the level of the conflict, overall conflict as measured by the SIM in the current study would not necessarily show the relationship. It might only be when conflict is examined at the higher-order level that this emerges, and the vast majority of retrospectively coded goals were lower-order. This might account for the discrepancy with Pomaki, Maes, and ter Doest's (2004) finding that goal conflict was related to increased Emotional Exhaustion because their study explored 'midlevel goals' which they describe as more concrete than higher-order abstract goals (set within a 12-month

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limited time-frame), yet not as specific as simple behaviours. It is possible these goals represented higher level conflict than the level of conflict generally evoked by the SIM. This argument is particularly supported by the following finding for hypothesis 2b which found burnout related to conflict at higher levels of goal abstraction.

Hypothesis 2b. Hypothesis 2b was partially supported. When goals were separated into lower and higher-order, a correlation was found between greater higher-order goal facilitation and higher Professional Accomplishment. As predicted, the correlation with reduced burnout was stronger at the higher than the lower level. This supported Kelly et al.'s (2015) review which suggested that lower level conflicts are less likely to predict well-being than those at higher levels in an individual's goal hierarchy. Emmons (1992) argued that higher level conflict results in greater disruptive consequences to the individual due to these goals being more intrapsychic and self-definitional. The association found would therefore imply that being unable to manage conflictual demands between important, and more abstract values and needs, negatively impacted trainees' professional well-being. However, no relationships were found between level of conflict, Emotional Exhaustion, Depersonalisation and difficulty attaining goals.

Goal facilitation refers to when pursuing one goal increases (rather than interfering with as in the case of conflict) the chances of success in attaining another goal. It became apparent that research has implied that goal conflict and facilitation are bi-polar opposites, but that they may represent different constructs (Gray, Ozer & Rosenthal, 2017). Indeed, Riediger and Freund (2004) did not find a correlation between goal facilitation and interference and, Boudreaux and Ozer's (2013) review of conflict research found interference associated with negative, while facilitation

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was associated with positive affect. Further, it has been argued that matrix-based approaches tend to measure the degree of inter-goal support as opposed to conflict (Kelly et al., 2015; Sheldon & Kasser, 1995). The SIM captures that on average a person's goals help as oppose to harm one another (Emmons & King, 1988), and Michalak, Heidenreich and Hoyer (2011) point out that bipolar conflict measures are typically skewed towards ratings on the scale which capture facilitation, therefore better representing the integration of goals. Hence, this study may have measured the degree of goal facilitation rather than interference. This may account for why greater facilitation (between higher-order goals) was associated with increased Professional Accomplishment; unlike the other domains of the Maslach Inventory, burnout scores for this sub-scale are reversed, and it thus relates to positive affect. In contrast, Emotional Exhaustion and Depersonalisation relate to negative affect, which might be why there was no link between goal facilitation and burnout. To account for this finding theoretically, the literature suggests that goal conflict (as opposed to facilitation) may be inherently associated with distress, as the distress signals that one's goals require changing due to being incompatible (Gray, Ozer & Rosenthal, 2017), which is supported by evidence that conflict is linked to greater rumination and inhibition (e.g. Cantor et al., 1992; Schultheiss, Jones, Davis & Kley, 2008). Conversely, as Sheldon and Elliot (1999) highlighted, it is not just the setting of goals, but succeeding with some form of movement towards them which is important for well-being; a notion supported by the finding that progression with goals is more related to positive psychological well-being than distress (Klug & Maier, 2015). Hence, the positive effects of Professional Accomplishment may not be simply due to the absence of conflict, but presumably would be due to the trainee's experience of their higher-order goals as mutually supportive enough to be attainable.

Managing goal conflict: moderating the negative effects? Kelly et al.

(2015) argue it is not simply the existence of goal interference that undermines self-regulation and well-being, but how able the individual is to manage the multiple demands of conflicting goals over time. Indeed, conflict is ubiquitous in everyday life (Karoly, 1999) and hence by itself is unlikely to account for the detrimental impact conflict has been found to exert on well-being. They support Mansell's (2005) proposal that poor outcomes likely result from conflict which is unresolved and chronic.

This raises the issue of whether goal conflict per se is the problem or how the therapist approaches goal conflict. The findings might therefore positively suggest that trainees are generally managing goal conflict well. Some therapists may have experienced conflict but addressed it well by discussing it openly during supervision. Boudreaux and Ozer (2013) propose that lack of progress towards goals can result in a rise in psychological distress. In turn, this may push the individual to renegotiate their goals or the strategies employed to reach them. They outline a variety of manners in which goal conflict be resolved. Although changes in one's environment may lead to a spontaneous resolution of a conflict, one may discover a means of achieving both conflictual goals, or attempt to achieve one goal at the expense of another (Wilensky, 1983). One might also accept conflict as an inevitable result of pursuing what they want (Riediger & Freund, 2004), which may reduce the negative emotional outcome of conflict. Indeed, how able individuals are to tolerate ambiguity in the conflict situation may be more instrumental in determining its adverse effects (Mansell, 2005). It is therefore possible that the trainees were already employing these goal regulatory processes. Further, as noted in the introduction, goal conflict can have positive effects (Brim & Kagan, 1980). For

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example, if conflicts are perceived, one may then be able to reprioritise their goals which may be more optimal to the individual's development (Cropanzano, Citera & Howes, 1995). This may have buffered against the expected negative effects of conflict generally for trainees, as well as may account for the lack of associations between Emotional Exhaustion, Depersonalisation and higher-order conflict.

Total Ambivalence/Conflict Scores and Burnout

As noted in the introduction, an average conflict score and a conflict score for each goal are produced from the SIM. However, the dependent variable of burnout (unlike goal difficulty) was measured at the individual level and not at the level of a participant's goals. Similar to Kelly et al.'s (2011) research on associations between conflict and depression, this meant that burnout was compared to the mean conflict score. The negative effects of particular conflicts might have been more potent than others, but the influence of this on burnout may have been masked by the average.

Sample characteristics. The sample was, on the whole, low in Emotional Exhaustion and Depersonalisation. Due to the low variance, a larger sample size might be needed to detect a small effect between these variables and goal conflict. Interestingly, the majority of the sample was in the mid-range of Professional Accomplishment, which may also account for why an association was found between this and high-level conflict.

The study relied on convenience sampling, which is susceptible to bias; those who chose to participate may have differed in some significant way which may not be representative of the norm trainee psychologist population (Barker, Elliot & Pistrang, 2002). For example, participants being aware the study was interested in 'therapist goals' may have attracted trainees who had distinctly stronger clarity about

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what their goals are, and how they might actualise these (and may consequently not have experienced the typical problems associated with goal conflict). In addition, the validity of self-report measures has been questioned (Barker et al., 2002). The nature of being a trainee may have caused some participants to feel reluctant to state if they were experiencing symptoms of burnout, or were not achieving important goals, because they might have feared judgement or professional repercussions.

Sample size and power. Despite every effort made to recruit to target, the power of the study to detect significance at the $p < .01$ level was reduced by recruiting 52 rather than 68 participants. The finding that higher-order facilitation was associated with burnout was only significant at $p < .05$, meaning that this might only be treated as trending towards significance. Due to multiple comparisons, it would be expected that one in 20 of these would by chance be significant. As the Bonferroni correction is recognised as highly conservative (Perneger, 1998), it was not used. However, this does not apply to the association found between ambivalence and difficulty attaining goals which was significant at $p < 0.001$. The results also provide an estimate of an effect size for a larger study. Regarding recruitment difficulties, it is noted that the inclusion criteria was limited to London-based trainings, and one of these programmes refused to pass on study information to their cohorts. Further, many trainee psychologists might not have wanted to commit to taking part due to their presumably high training-related obligations.

Content of Goals Generated. Based on what participants thought the researcher was looking for, demand characteristics (Orne, 1962) may have led to them presenting goals in particular ways. Social desirability bias (Tourangeau & Yan, 2007) may have led them to create a favourable impression by stating goals which demonstrate they are caring practitioners. It would understandably be uncomfortable

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for a trainee to state a goal which they feel would be judged negatively, such as that they are often aware of the time and hope for the sessions to pass quickly so that they can leave work. It might also be argued that trainees might be more likely to say 'approved' goals not only due to social desirability, but also because they are more cognitively available. Indeed, many participants appeared to struggle after reporting several goals. Perhaps under performance anxiety, they exhibited a form of availability heuristic (Kahneman & Tversky, 1979), relying on any goals they could recall (e.g. from general competency frameworks), even if they had little personal relevance. The goal interview could arguably have become an abstract task for participants in naming standard goals. As the goals might not be representative of what they are striving for in their clinical roles, they might not have been personally meaningful enough to relate to burnout.

As noted, participants mainly generated lower-order goals. This makes sense within the context of asking them what they are trying to achieve within therapy sessions and more generally within their services, as it might be natural for them to immediately think of practical 'doing' goals. It is interesting that for many participants, more abstract goals were raised towards the end of the interview, supporting the notion that the nature of the measure typically directed their initial attention towards concrete strivings. It therefore does not seem that participants did not understand the task, but rather that the method was not designed to extract higher-order goals as readily as lower-order goals. Moreover, no obvious differences in types of goals generated were noticed between trainees previously known and unknown to the researcher, which might suggest that the lack of higher-order goals generated was more likely fundamental to the measure used and not the

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comfortability of the participants to reveal these. The future research section below provides suggestions for how higher-order goals might be better accessed.

While this study attempted to retrospectively homogenise goals to the same level using Wallenius' (2000) coding framework, only half of participants could be compared on these variables due to the limited number of higher-order goals generated. Many participants only revealed two higher-order goals meaning that the conflict score at this level was calculated by one single goal interaction. Where participants raised only one higher-order goal, no conflict interactions at this level could be produced. This may account for the lack of association between higher-order conflict and the outcomes of Emotional Exhaustion, Depersonalisation and difficulty attaining goals. Furthermore, coding issues became apparent as many statements were ambiguous, and Kappa (.64) was only slightly above 'substantial' (Landis & Koch, 1977). For example, 'being genuine' could have been a relational higher-order goal, but it could also be perceived by them as a simple behavioural 'doing' goal in line with following competencies around establishing and maintaining therapeutic alliances. It was agreed to place these goals in the latter category due to it being assumed that trainees are most likely pursuing goals to satisfy competencies. However, the validity of such levels of abstraction ascribed to participant goals may be questioned.

High level conflicts which would be theoretically expected to exert a more powerful influence on well-being and goal progression may have not been fully captured, even by retrospectively coding them via Wallenius' (2000) framework. For example, many relational goals coded as higher-order, such as to be perceived as competent by colleagues, appeared as though they could relate to conflicts around actual, ideal and ought self-representations (Higgins, 1987). However, the SIM

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produces great heterogeneity between goal levels (Gray, Ozer & Rosenthal, 2017), and while other goals may or may not have been in the service of this higher-order self-representation (to be perceived as competent), it is not designed to specifically extract and measure self-representational conflicts. In addition, many higher-order goals also appeared related to the trainee's more intrinsic values, such as 'to maintain integrity as a therapist by speaking up for service-users in the team'. Sheldon and Kasser (1995) have argued against the notion that it matters whether strivings conflict, but whether they are facilitative of the person's more fundamental needs or values. However, in the current study it was unknown whether participants' goals, were in Deci and Ryan's (1985, 2000) terms, self-determined rather than forced upon by external circumstances.

Conscious Versus Unconscious Conflict. Matrix-based assessments like the SIM ask participants to directly report on the interaction between their goals, and so it can be said to measure conflict that is explicitly available to conscious awareness. Conversely, less conscious conflict which is outside awareness, or at least gets limited sustained awareness, is by definition not so amenable to self-report (Kelly et al., 2015). Michalak, Heidenreich and Hoyer (2004) found only found a low correlation ($r = .07$) between measures claiming to implicitly assess non-conscious conflict, and other matrix forms of conflict assessment including the SIM, which indicates they do not investigate the same type of conflict. With regard to the relevance to this study, less conscious conflict may be more problematic to the individual because there is likely to be greater difficulty in finding a resolution when the conflict resides outside awareness (e.g. Higginson, Mansell & Wood, 2011; Mansell, 2005). This highlights how the SIM may not have tapped into the more

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insidious forms of conflict for participants.

Limitations Summary

It was highlighted that the study was underpowered due to failing to recruit the requisite sample size. As some findings were only found significant at the $p < .05$ level, caution must be taken when interpreting results. The study also employed a cross-sectional design, meaning that causality cannot be assumed between the correlations observed. As the study did not measure whether conflict was sustained over time, this could mean that the pervasiveness of goal conflict was not always sufficient to exert an undermining effect on emotional regulation and goal attainment. At the same time, the extent to which participants were successfully employing strategies to resolve or tolerate conflict was unknown, which may moderate the relationship between conflict and the outcome variables. The study measures also all relied on subjective self-report. This may have made the reporting of burnout particularly difficult for some participants due to fearing negative evaluation. Similarly, the sample may have been biased in terms of burnout levels, and goal characteristics.

It was highlighted in the literature that the SIM produces the weakest evidence across studies for the negative impact of goal conflict. It arguably is a more appropriate measure of goal facilitation, and relies on conscious reporting of conflict which may be less disruptive than non-conscious conflict. In addition, both conflict and ambivalence means were used to explore their relationship with burnout; this may have masked the detrimental effects of particularly troublesome conflicts.

Conceptual difficulties in categorising the abstractness of goals were noted, and so the framework used to ascribe goal level may not have appropriately

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identified these. However, substantial inter-rater agreement was reached. More problematically, the majority of participant goals were lower-order, which made comparisons between these and higher-order goals difficult.

Clinical/Training Implications

The results suggested that when trainee psychologists experience conflict between their more abstract motives, values and relational needs, they are likely to experience symptoms of burnout. More generally, when experiencing mixed motivations about the prospect of achieving a goal, they are more likely to find it difficult to succeed with that striving. Consistent with the literature, these findings highlighted the undesired outcomes of trying to attain multiple goals which demand the same resources, such as time, effort, and attention. As highlighted in the introduction, the negative effects of chronic stress and burnout in the human-services professions are well-documented and include affective well-being, impaired occupational functioning, absenteeism, poor morale, mental and physical illness and workforce turnover (Jenaro et al. 2007; Ruotsalainen, Verbeek, Mariné & Serra, 2014; Sutherland & Cooper, 1990). Given that both trainee and qualified psychologists appear to be vulnerable to stress-related impairment which might negatively impact their practice (Guy, Poelstra & Stark, 1989; Hannigan, Edwards & Burnard, 2016; Pakenham & Stafford-Brown, 2012), the findings of this study suggest that targeting goal conflicts may be conducive to the well-being and potential effectiveness of clinicians.

Goals existing at higher levels are less likely to be conscious to the individual in their everyday lives despite daily behaviour being driven by them (Carver & Scheier, 1982; Emmons, 1999). Therefore, a first step to targeting these conflicts would be to help trainees become more aware of their higher-order goals. Their

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identification might help a person to clarify what their goals are, which could involve a re-appraisal of how their goals are interpreted. Method of Levels is a therapy derived from Perceptual Control Theory (Powers, 1973) and may offer useful insights in how this might be achieved. For example, a trainee might experience ambivalence toward the goal of setting session agendas or boundaries which is what might be expected from a therapy model they are using. Inviting them to notice their awareness at higher levels (the level of beliefs and values) might reveal that a trainee feels that being a good and helpful therapist involves being led by clients, and not impinging on what they need to speak about. They might then notice that this value plays a part in generating the conflict. The trainee could then be helped to re-evaluate the lower level behavioural goal of setting boundaries and agendas in terms of the benefit it might have for the patient, such as in reinforcing structure in their lives. This in turn may help the trainee to see how this goal is more facilitative of their higher-order value of being a helpful therapist than it initially appeared, which may resolve the conflict. Helping trainees become more aware of their individual motives and values might also be helpful in terms of goal prioritisation. This can increase attention and committed effort towards valued outcomes, making attainment more likely by removing resources from competing goals (Kruglanski et al., 2013). Moreover, the negative emotional effects of conflict may be overcome by the positive effects of maintaining engagement with goals important to the individual (Seegerstrom & Solberg Nes, 2006). These techniques for addressing goal conflict could occur during supervision (perhaps forming a part of supervisor competencies), or tutor appraisals.

Many participants stated that the goal interview method in the current study was helpful for clarifying their goals and their struggles with attaining them. Some

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even reported using it as reflection tool during tutor reviews and supervision. Alternatively, the recently developed 'Goal identification questionnaire' (GIQ; Fowler, Hulme, Hussain, Mansell & Wilcoxon, 2016) could be used to understand therapists' goals within the context of their personal hierarchy. It is noted that demands from training come from clinical, academic and research areas (Cahir & Morris, 1991), and hence the identification of goals and how these are to be managed will most likely depend on what is most important in the context of the more externally imposed requirements of the programme, and the trainees own personal needs and values.

Finally, it is acknowledged that this paper has focused more on burnout at the expense of the related concept compassion fatigue. As noted in the literature review, while burnout in the work setting is understood as resulting from work-related factors such as practitioner autonomy, caseload, and having rewarding relationships (Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013), compassion fatigue is defined as being unable to engage in the caring relationship with the service-user (Sabo, 2011). However, both burnout and compassion fatigue likely overlap due to the significant relationship found between these concepts in research (Mol et al., 2015). Therefore, it might be expected that the goal conflict factor associated with burnout in this study might also relate to the clinical issue of compassion fatigue.

Future research

It has been documented that stress and work-related impairment might be measured in other ways which may overcome the potential for bias inherent when using subjective self-report measures (Hannigan, Edwards & Burnard, 2016). This might include at an indirect level (via sickleave and staff turnover), or via more

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direct means such as biochemical markers. Similarly, the discussion highlighted that conflict which is less conscious is less likely to be available for report.

Contemporary research has highlighted how markers of unconscious conflict may be identified via skin conductance responses and decision-time reactions (Kleiman & Hassin, 2011). Another commonly used conflict-investigation tool, the Computerized Intrapersonal Conflict Assessment (CICA) (Lauterbach, 1996), is argued to measure implicit conflict by the computer programme asking questions about different concepts and then indirectly assessing the degree of conflict between them.

Kelly et al. (2015) summarise a variety of methods used in various forms of conflict research which they argue, within their hierarchical model can measure conflict at higher levels. For example, to capture high level conflict between self-representations it would be important to examine the discrepancies among the domains of actual, ideal and ought selves (Higgins, 1987) of trainee psychologists. The Self Discrepancies Questionnaire (SDQ; Higgins, Klein, & Strauman, 1985) might be used for this, although the aforementioned CICA also explores inconsistencies between reality and attitudes which is argued to correspond to actual-self discrepancies (Kelly et al., 2015). Further, to explore the property of goal concordance participants could be asked to rate their motivations for pursuing their goals along intrinsically or extrinsically driven dimensions (Sheldon & Kasser, 1995).

Future research might also benefit from a longitudinal design in order to investigate causal relationships between conflict and outcome variables. A repeated-measures design might also highlight the impact which unresolved conflict,

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sustained over time, has on burnout and goal progression in trainee psychologists.

Sheldon's (1995) approach of asking participants to rate their confidence to tolerate conflicts could also help to ascertain a trainee's perception of their ability to manage the conflict. The results also provide an estimate of an effect size which could be used for a larger national, or international study.

Finally, it would be interesting to explore the effects of goal conflict on qualified practitioners due to how divergences between an experienced therapist's personal values or approach, which might have had more time to develop and strengthen (compared to a student who is still in the learning process), might be more pronounced in contrast with service requirements. Conflict between these factors might then exert a stronger effect resulting in greater burnout than it might for trainees. However, it is noted that recruitment issues may be even more difficult with this population who would be expected to already have busy work schedules.

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Part Three: Critical Appraisal

Introduction

Prior to embarking on the D.Clin.Psy., I had previously trained as a psychodynamic psychotherapist. It will first be discussed how this theoretical orientation influenced my approach to, and reflections around the research project. In addition, methodological and conceptual limitations about goal conflict research will be reflected on, which have been raised by this study. Throughout, learnings about the practical considerations when carrying out studies of this nature will be highlighted, which might be useful for future researchers to note.

Modality Conflicts

One difficulty I experienced transitioning from a psychodynamic orientation was about how to conceptually and practically integrate new theoretical ideas (e.g. Cognitive-Behavioural, Systemic) learnt on the Clinical Psychology training. Whereas psychotherapists tend to train in one broad orientation, Clinical Psychologists, in addition to following evidence-based modality interventions, draw upon a range of models to inform treatment (Johnstone & Dallos, 2006). Unlike eclecticism which applies in a more random way different theories to a particular instance, integration involves combining various models into one consistent approach, and this can be achieved in a number of ways; including by identifying common factors across modalities, or using the aspects of different models with the most demonstrated efficacy (Norcross & Goldfried, 2005). One early interest of mine about the prospect of goal conflict for therapists was how trainees might approach and handle conflicts between different theoretical bases. In the current study, goals pertaining to the application of specific therapeutic skills (e.g. to set behavioural exercises, or, to use make use of countertransference) were coding as lower-order 'doing' goals (Wallenius, 2000). However, it is interesting that the detrimental

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effects of conflict were found related to more abstract higher-order values (greater facilitation between these was associated with a higher sense of Professional Accomplishment). This finding might suggest that participants are typically managing conflicts inherent in using theoretically inconsistent orientations, or even between potential conflicts existing within models (such as finding a right balance between using time to focus on disorder-specific treatment protocols, and allowing time to develop the therapeutic alliance) well. However, as discussed, the Striving Instrumentality Matrix (SIM; Emmons & King, 1988) produced great heterogeneity in the types of goals generated, making comparisons like this difficult. Further potential thematic coding of goals is discussed later.

Goal Authenticity

Although it is noted that some participants did provide what might be considered more revealing or personal goals (e.g. that it was important for them to experience an 'ego boost' from positive client feedback), it was discussed how the goals often felt 'approved' and in line with what would be expected from general frameworks. I became aware of a difference I experienced between the culture of Clinical Psychology training as compared to the psychodynamic training, in terms of the emphasis on reflecting, from within a personal developmental context, on the early (potentially unconscious) determinants for why trainees might find themselves wanting to practice in the therapeutic field. Indeed, psychodynamic institutions usually mandate that trainees have personal therapy which can arguably help uncover unconscious motivations for behaviour (Malikiosi-Loizos, 2013), although it can also be argued that similar self-awareness develops from other self-development activities integral to psychology training such as via trainee self-reflection on reading, role-plays, experiential workshops, and supervision (Griffith &

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Frieden, 2000; Hawley, 2006; Ivey, 1973; Paladino, Barrio Minton & Kern, 2011; Dryden & Thorne, 2008; Wosket, 1999). However, this difference in my experience of the trainings made me generally think about the accessibility of less conventional personal abstract goals for Clinical Psychology trainees, and I wondered if this accounted for the more standard feel of the goals typically evoked in the current study. As Emmons (1999) noted, high level goals are less available to conscious awareness in the course of everyday life. Further, as discussed, due to the SIM relying on conscious awareness of conflict for it to be amenable to self-report, how aware trainees were of the conflicts pertaining to deeper motivational strivings might also be limited.

It is noted that even if more personal goals were accessible, most likely due to the context of the research situation it would be understandable that participants might not reveal too personal material. Indeed, one of the most difficult parts of developing this project I experienced was the question of how best to 'ground' the elicitation of goals and to explore them fully. The interview process made me reflect on the difficulty of avoiding demand characteristics (Orne, 1962), particularly when the researcher's presence is required. As noted in the discussion, some participants had trouble generating more than several goals, sometimes appearing they were struggling or slightly embarrassed by not being able to state what goals they have. In turn, perhaps wanting to appear competent they portrayed they knew exactly what they are trying to achieve with clients by drawing on whatever standard goals they could think of. This captured for me the difficulty in using self-report for goal conflict research where the generation of idiosyncratic content is required from participants.

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Sheldon and Elliott (1999) found that working towards self-concordant goals predicted goal attainment, and greater levels of wellbeing. Brunstein, Schultheiss and Grässmann (1998) conversely found that trying to achieve incongruent goals was linked to reducing well-being over time. Concordance in the current study was framed within Kelly, Wood & Mansell's (2015) model as a quality of the goal system, whereby deeper-rooted higher level motivations and values are supported by the goals they drive lower in the hierarchy. It might be presumed that goals which are felt as fulfilling more fundamental needs would relate more to internally motivated goals as opposed to those mandated by competency frameworks. It might therefore be useful to know if typically, competency goals are at odds, or work well alongside, trainee therapist's higher level beliefs and values. It was unfortunate the perceived concordance of goals was not assessed during this study, but it is noted that significant conceptual difficulties were identified in differentiating motivations which are external and internal for trainees. For example, even though a trainee might feel it less concordant to complete administration works, it would fit within the overall project of completing placement and ultimately qualifying, which might be experienced to be in line with strong intrinsic needs.

Assessing the Impact of Goal Conflict

The goal conflict literature, and the current study findings, presented difficulties with the conceptual and methodological limitations of investigating goal conflict. The SIM was identified as one of the most common methods of investigating conflict, an approach which appears to have strong face validity, and reported one-year reliability. However, a main issue was noted in this study around its use of a total conflict score, which had to be used to compare with burnout due to the latter dependent variable being measured at the level of the individual (not in

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relation to each goal). It was highlighted how this could occlude the effects of powerful individual conflicts, which may have been more disruptive to a participant in terms of their experience of burnout. This made me reflect on the difficulty in measuring the extent to which a specific conflict between goals has upon an individual. Indeed, it has been proposed that it is not conflict itself that causes distress, but its pervasive and chronic nature (Powers, 1973; Mansell, 2005). As with most papers in the goal conflict literature (Kelly et al., 2015), this study's investigation of conflict was of a snapshot in time. It is noted that a longitudinal design was considered during the proposal stage, which involved the use of the SIM at two time points. However, this tool had no data reported on its sensitivity to detect change in conflict over time, so this idea was abandoned.

As noted, there exist numerous factors which could moderate the relationship between conflict and distress, such as how able one feels to tolerate conflict (Mansell, 2005), or how the person re-negotiates strategies to achieve their goals (Wilensky, 1983) which trainees might have done well in supervision. Initially coming from a theoretical orientation concerned with meaning-making with individuals, I developed an interest in qualitative methodology, and I had hoped to include a qualitative component to the study. Indeed, because this is a new area, it might be particularly useful to hear a participant's experiences directly. The literature review highlighted the value of mixed-method approaches for observing associations between variables such as social support and stress, but also understanding what it is about social relationships that trainee psychologists find particularly useful in the context of training (Bowlin, 2014). Regarding future research, interviews and thematic analysis (Braun & Clarke, 2006) could be used to explore not only how trainees experience the negative effects of conflict in terms of

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work-related well-being, but also in terms of what trainees perceive as influencing the extent of conflict becoming deleterious (e.g. how they manage the conflicts). Unfortunately, whilst considered during the proposal stage, time limitations made this difficult to actualise as the study already required conducting interviews, and creating a personal goal matrix for each participant post-interview.

It became apparent through researching the literature, that no precise definition of goal conflict exists. Segerstrom and Solberg Nes (2006) highlight that at times it has been understood as a unitary construct for all forms of conflict between goals. However, they point out that distinctions can be drawn between conflicts which are inherent to the individual and those which are more resulting from environmental (e.g. resource-based) influences. It was revealing that many participants commented during the interview that they experienced greater ambivalence and difficulty achieving goals (such as around maintaining a manageable caseload and completing administration work) in the context of pressures to see a high volume of patients in services such as IAPT, compared to the placement setting they resided in at time of interview. However, this was unsubstantiated by the data as placement type was not recorded. Segerstrom and Solberg Nes (2006) highlighted how resolution of goals might similarly depend on more intrapsychic, or the external cause of the conflict, and so in environments where limited resources, such as time, cannot be extended to resolve conflicts, the adverse outcomes of conflict might be more apparent for trainee psychologists. This might be an important area for future research to explore given the demanding contexts Clinical Psychologists can operate in (Anagnostopoulos & Niakas, 2010; Grant & Campbell, 2007; Grigsby, 2016, Jenaro et al., 2007; Linley & Joseph, 2007). Again, an original early idea for the current study was using a sample of

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qualified therapists from IAPT and to compare this with therapists working in other services (e.g. community-based). However, it was questioned if it would be possible to recruit the requisite number of qualified therapists' due to the workload pressures they might already be under. Indeed, the current study failed to meet the target of 68 participants despite efforts taken, which highlighted to me the importance of establishing a feasible sample size when planning research.

As the SIM instructions needed adjustment for eliciting the goals of psychologists, it was apparent that a therapist could have general goals they are trying to achieve, or goals with specific patients (which might or might not coincide with the patient's own goals). In addition to asking for 'typical goals', participants were asked about specific instances of conflicts, from which the general striving informing this was attempted to be elucidated. Further, they were told goals might relate to the actual practice of therapy, or could be about what they must achieve more generally in their placements. In this way, the study attempted to sample goals as fully as possible. However, this highlighted to me early on in the design phase the various ways the investigation of goal conflict in this population could be approached, and the need to do so in a consistent way so that data is fairly comparable between participants.

It is also noted that many participants during the interview expressed confusion regarding why they would be unhappy if they were to succeed in an outcome they felt they wanted to seek (the ambivalence item). Although clarifications were attempted, it seemed that some participants remained unsure about what was being asked of them. I initially considered this a major issue, but came to understand that even if a participant does not understand the purpose of a question, this does not necessitate a problem with its construct validity. However,

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while Emmon's (1986) ambivalence item has demonstrated associations across a number of studies with anxiety and depression (see Kelly et al., 2015), and has good reported reliability, it is wondered if the wording of this question was changed, might it tap more into the experience of ambivalence in future research. Part of the confusion may be that by asking how unhappy they would be to *achieve* a goal, it might cause the individual to imagine simply the end state of achieving that goal which might not in itself be problematic (e.g. to complete admin work). However, this might not capture the true complications and inherent ambivalence about the actual process of pursuing those goals in reality (e.g. the frustration of having to stay late at work to finish admin notes). It might therefore be more appropriate to ask participants to rate '*how unhappy would you be if you were to try to pursue*' the goal in question.

Categorisation of goals

Goals were retrospectively broadly coded into lower and higher-order. However, the discussion highlighted how, to more fully explore conflict at specific levels, somehow the idiosyncratic goal hierarchy of the participant would need to be known. Without this guidance, goals from different points in the hierarchy are pitched against each other in the SIM. Indeed, conflict between goals at different levels could be arguably redundant because they do not have psychological significance. Only goals at the same level and tied into the same part of the hierarchy would produce distress (Kelly et al., 2015). The findings of this study regarding the lack of association between mean conflict and burnout appear to support understandings for the mixed findings in goal conflict research which is arguably due to the fairly arbitrary nature of the SIM with respect to goal levels generated.

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It was considered using the Goal Identification Questionnaire (GIQ; Fowler, Hulme, Hussain, Mansell & Wilcoxon, 2016) to map out a participant's goal hierarchy initially. However, it seemed that the resources of the research and the participants might be insufficient due to the time and effort it would require on a participant's part to map their goals into a personal hierarchy over more than one meeting, also increasing potential for participant drop out. This again highlighted to me early on the importance of establishing procedures which were manageable for potential volunteers. However, it was unfortunate that further coding of the goals did not occur due to time limitations. It would have been interesting to explore if conflicts associated with relational-based goals, or, as mentioned earlier, about the integration of different therapeutic modalities, were related to increased burnout. This is an analysis that could still occur on the goal data gathered, or an idea to be used in future research. One problematic reason with using a pre-existing goal coding framework such as Emmon's (2003), was that this yielded several categories (e.g. intimacy, power, achievement, and self-presentation), and to reach a strong standard of inter-rated reliability seemed ambitious given time constraints. Indeed, the study highlighted difficulties even when broadly coding goals into lower and higher-order, with agreement only slightly above substantial.

Overall Experience

Reflecting on the overall experience, the project has been anxiety-inducing at times. This may be largely due to the noted methodological complexities (including at a theoretical and a practical level) about investigating goal conflict, and also because exploring it with the current population is new territory requiring significant modifications in approach. This has meant that the project was constantly evolving during the proposal stage, and many learnings emerged during implementing and

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interpreting the findings, which could be used to refine or expand upon the foundations laid by this research in future studies. Interestingly, there are notable experiential comparisons for me in terms of the pragmatism required with this study to the process of completing the literature review, which had to incorporate grey literature due to stress/burnout in trainee psychologists being a relatively understudied area. At the same time, the engagement with goal conflict literature which might be considered to exist within the fringe area of psychology research, has been an exciting process, which has exposed me to other ways of thinking about subjective well-being and behaviour not traditionally represented during training, and which in this study were found to have significant implications for practitioners in the field.

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Appendices

Appendix A

Predictor Variable Measures used Across Studies

Variable domain	Measure	Studies used
Personality	<i>NEO Five-Factor Inventory, Third Edition</i> (NEO-FFI-3; Costa & McCrea, 1992). Measures Neuroticism (N), Extraversion (E), Openness to New Experiences (O), Agreeableness (A), and Conscientiousness (C)	Grigsby, 2016
	<i>Interpersonal Reactivity Index</i> (IRI; Davis, 1980). Measure dispositional empathy	Micheli, 2015
	<i>International Personality Item Pool</i> (IPIP; Goldberg et al., 2006). Measures Neuroticism (N), Extraversion (E), Openness to New Experiences (O), Agreeableness (A), and Conscientiousness (C)	Riise, 2012
Coping	<i>Coping Inventory for Stressful Situations</i> (CISS; Endler & Parker, 1990). Measures coping styles (Task-Oriented (TO), Emotion-Oriented (EO), and Avoidance-Oriented (AO))	Grigsby, 2016
	<i>Coping Orientations to Problems Experienced Inventory</i> (COPE; Carver, Scheier, & Weintraub, 1989). Assesses coping behaviours.	Drake, 2011
	<i>Student Coping Instrument</i> (SCOPE; Struthers, Perry, & Menec, 2000). Assesses coping behaviour (Problem/Emotion Focused in students)	Riise, 2012
Self-care	<i>Well-Functioning Questionnaire</i> (WFQ; Coster & Schwebel, 1997). Measures factors which contribute to Psychologist well-functioning	Shotwell, 2014, Armstrong, 2015, Scarborough, 2009,

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Modified based on Case & McMinn (2001) and reworded to explore frequency rather than importance

ratings

<i>Godin Leisure Time Exercise Questionnaire</i> (GLTEQ; Godin & Shephard, 1985). Assesses engagement in physical activities	Myers, Sweeney, Popick, Wesley, Bordfeld & Fingerhut, 2012
<i>Creative Activities Survey</i> (designed by authors). Assesses self-reported frequency of participation in a variety of self-care activities	Shaw, 2013
<i>The Sleep Hygiene Index</i> (Mastin, Bryson, Corwyn, 2006). Assesses sleep hygiene behaviours	Myers, Sweeney, Popick, Wesley, Bordfeld & Fingerhut, 2012
<i>The Emotion Regulation Questionnaire</i> (ERQ; Gross & John, 2003). Measures emotion regulation strategies (cognitive reappraisal and expressive suppression)	Myers, Sweeney, Popick, Wesley, Bordfeld & Fingerhut, 2012
<i>Mindfulness questionnaire</i> (Designed by authors). Measures individual's practice of mindfulness	Myers, Sweeney, Popick, Wesley, Bordfeld & Fingerhut, 2012
Social Support	<i>Multidimensional Scale of Perceived Social Support</i> (MPSS; Zimet, Dahlem, Zimet & Farley, 1988). Measures perceived social support
<i>Collegiate Psychological Sense of Community scale</i> (PSC; Lounsbury & DeNeui, 1996). Slightly modified to address psychology programs	Fingerhut, 2012, Townsend, 2011 Townsend, 2011, Clark, Murdock, & Koetting, 2009

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	<i>Significant Others Scale</i> (SOS; Power et al., 1988). Assesses social support from a confidante outside of work	Brooks, Holttum, & Lavender, 2012
	<i>Social Support Measure</i> (items developed by Caplan, Cobb, French, Van Harrison, and Pinneau, 1975) and modified by Ray and Miller (1994). Measures social support (advisor, other students, and family/friends)	Clark, Murdock, & Koetting, 2009
	<i>The Dydactic Satisfaction Subscale of the Dydactic Adjustment Scale</i> (Spainer, 1976). Scales overall adjustment to and subjective quality of a two-person relationship	Bowlin, 2014
Course environment	<i>The Intervention Questionnaire</i> (Schwebel & Coster, 1998). Modified to measure techniques employed by training programs to enhance career satisfaction and mitigate against professional impairment	Montgomery, 2010
Quality of Life/Work	<i>Satisfaction With Life Scale</i> (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). Assesses life satisfaction/well-being	Townsend, 2011
	Modified to distinguish personal/professional satisfaction	Montgomery, 2010
	<i>The Quality of Life Scale</i> (QOLS; Flanagan, 1978). Measures satisfaction with life circumstances	Armstrong, 2015
	<i>Job Satisfaction Survey</i> (JSS; Spector, 1985). Assesses employee attitudes about their job in human services professions	Micheli, 2015

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Appendix B

Recruitment E-Mails

E-Mail to Courses:

Dear [Name of London-based Clinical Psychology training institute]

My name is Sam Russ and I am a second year UCL trainee Clinical Psychologist. I am writing to invite your Trainee Clinical Psychologists to take part in my doctoral thesis research.

We would like to learn, from Trainee Psychologists themselves, what goals they strive for, and how these relate to both their well-being and their work with clients. We aim to recruit trainees from London-based courses so that a range of experiences can contribute to this research. The study has UCL ethical approval.

If it is acceptable to you to inform your trainees about this research, I can send you an E-Mail Advert to circulate.

I have attached an information sheet with more information about the research, but please do contact me if you would like to know more or have any concerns.

Thank you,
Sam Russ

Trainee Clinical Psychologist, UCL
samuel.russ.14@ucl.ac.uk

E-Mail to potential participants:

Dear Fellow Clinical Psychology Trainee,

While client goals are viewed as central to most therapeutic interventions, it is surprising that little attention has been given to therapists' goals. This study explores how our goals shape both our work with clients and Influence our well-being as Psychologists. This research is being carried out as part of my DClInPsy thesis at UCL, and has UCL ethical approval.

I am hoping that trainees from a number of London-based courses will be interested in taking part so that a range of experiences can contribute to this new research area. The process should take no more than an hour of your time. One participant will also be randomly selected to win a prize of £150.

I have attached an information sheet which outlines what the study will involve, and how to take part.

I hope to hear back from you if you are interested in participating or have any questions,

Best,
Sam Russ
Trainee Clinical Psychologist, UCL
samuel.russ.14@ucl.ac.uk

Therapist Goals Research: Information Sheet

The purpose of this letter is to provide you with the information needed in order to decide whether to participate in a research study. The study is being conducted as part of my Clinical Psychology Doctorate at University College London (UCL).

****£150 will be randomly allocated to one participant for taking part!****

Why is this research important, and why might I want to help?

We would like to learn, from Trainees themselves, what goals they strive for, and how their goals shape both their work with clients and influence their well-being as Psychologists. We aim to recruit around 50 Trainees.

Please note that this is not a test of your therapy knowledge of competence.

What will I have to do?

- **Time commitment:** Approximately one hour of your time in total.
- **Location:** The researcher will be available to meet on a UCL site, but will try to arrange a meeting at a place convenient to you. Or, a telephone/Skype meeting can be arranged.
- **What will happen:** With the guidance of the researcher, you will be helped to identify the goals that you are trying to achieve in your sessions with clients. You will then be asked to rate how these goals relate to one another. Finally, in your own time you will be asked to fill out a short work-related well-being questionnaire sent to you via E-Mail.

What if I don't want to take part?

You are not obliged to take part in this study. You are also free to withdraw at any time and you may do so without disadvantage to yourself and without any obligation to give a reason.

Will my data be confidential?

Therapist Goals and Goal Conflict

All data will be anonymised so that you will not be able to be identified in the report of the study. All data will be collected and stored in accordance with the Data Protection Act 1998, with only access to by the researchers, and will be securely disposed of at the end of the study.

Are there any risks?

There are no more identified risks to taking part in this study than would be expected if you were to reflect upon your everyday clinical practice. It is hoped that this exercise may even positively contribute to the work you do with clients. This study has been approved by the UCL Research Ethics Committee (Project ID Number: 4901/001).

If you are acutely distressed by the experience of participation you will be provided with support by the researcher. If you are not reassured then the number of the project supervisor, a registered Clinical Psychologist will be given. He will then be able to provide additional support and signposting for further help.

What must I need to participate?

- be enrolled on a Doctorate in Clinical Psychology
- have completed a six-month clinical placement offering psychological therapy
- be fluent in understanding English in order to follow the verbal and written instructions

How do I participate or learn more?

If you are happy to take part you will be asked to sign a consent form prior to your participation.

Please contact me in any of the following ways to continue, or to find out more information:

Sam Russ
E-Mail: Samuel.russ.14@ucl.ac.uk
Mobile: 07429 285 738

[Supervisor: Dr. Vyv Huddy E-Mail: v.huddy@ucl.ac.uk]

Thank you for reading this information sheet and for considering taking part in this research.

Therapist Goals Research: Consent Form

Please complete this form after you have read the Information Sheet

This study has been approved by the UCL Research Ethics Committee (Project ID Number):
4901/001

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you.

If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Participant's Statement

I

- have read the notes written above and the Information Sheet, and understand what the study involves.
- understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
- consent to the processing of my personal information for the purposes of this research study.
- understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.
- agree that my data, after it has been fully anonymised, can be shared with other researchers *[to satisfy Research Council funded projects as Research Councils have changed their guidance regarding data sharing]*

Signed:

Date:

Therapist Goals Research

SEMI-STRUCTURED INTERVIEW PROTOCOL

"I would like to help you explore a number of goals or objectives you are trying to accomplish during your therapy sessions with clients, or more widely in your service. A goal may be important to you on a personal level, or important to achieve in the service where you work. As we go along I will also ask you for some ratings about each goal. I will also explore how you are progressing with that goal, and how your other goals might interact with this. We will stop after we have captured around several goals. Examples of goals might be: "I want to show the client I am interested in helping them", or "I need to check for client risk each week".

"Please remember that there are no right answers; different goals from different therapists and models are to be expected. This is in no way a test of your competence. Do not worry if it is difficult identifying your goals as we don't tend to always explicitly think about them. I will offer some prompts if you become stuck. Do you have any questions at this stage? "

[Ask for first goal]

Prompts

"To help you think about your goals, you might find it helpful to imagine a typical therapy scenario. For example, the last client you worked or ended with, or a 'typical' first session with a new referral"

"...perhaps you could think about a case you have brought to supervision..."

If participant is only stating goals pertaining to therapy sessions:

"What about objectives that are expected in your service, for example around the management of your clinical work?"

Ratings of goals:

1. "How unhappy would you be if you succeeded at this goal, on a scale of 0, "not unhappy at all", to 5, "extremely unhappy"?"
2. "How difficult is it for you to succeed with this goal, on a scale of 0, "not difficult at all" to 5, "extremely difficult"?"

If participant expresses any difficulty with attaining a goal (e.g. rated over '0' or indicated

Therapist Goals and Goal Conflict

verbally):

"Could you say more about how progressing with that goal is difficult?"

If it appears that something external to the client (for example in their environment) is preventing them from achieving a goal, they will be asked how they respond to that, in order to elicit what their goal in that situation would be:

"What would you do to achieve the goal you previously mentioned when this happens?"

"How do you manage that?"

If another of the participant's goals is conflicting with progressing with a prior stated goal, the participant will be helped to frame this as a goal:

"Could you frame what you have just said in terms of another of your goals in sessions, starting again with 'I want... or I need...'?"

After the goal has been appropriately identified, explore goal progress as above.

Continue process until at least ten goals are identified.

Therapist Goals and Goal Conflict

Appendix F

Striving Instrumentality Matrix (SIM) Example

Participant Code:

Now that you have identified what goals are important to you, we will explore how these goals relate to one another. Does being successful in this striving have a helpful, harmful, or no effect at all on the other striving? Give a rating from the below scale of very harmful (-2) to very helpful (2).

Very harmful effect	Somewhat harmful effect	No effect	Somewhat helpful effect	Very helpful effect
-2	-1	0	1	2

Goals	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8	Goal 9	Goal 10
Goal 1	n/a									
Goal 2		n/a								
Goal 3			n/a							
Goal 4				n/a						
Goal 5					n/a					
Goal 6						n/a				
Goal 7							n/a			
Goal 8								n/a		
Goal 9									n/a	
Goal 10										n/a

Appendix G

UCL Ethical Approval

Dr Vyv Huddy

Division of Psychology and Language Sciences

UCL

Dear Dr Huddy

Notification of Ethical Approval

Re: Ethics Application 4901/001: Trainee Therapist Goals and Conflicts

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee that I have ethically approved your study until 1st October 2017.

Approval is subject to the following conditions.

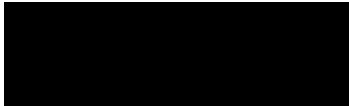
1. You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form': <http://ethics.grad.ucl.ac.uk/responsibilities.php>
2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.
3. For non-serious adverse events the Chair or Vice-Chair of the Ethics Committee should again be notified via the Ethics Committee Administrator (ethics@ucl.ac.uk) within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair will confirm that the incident is non-serious and report to the

Therapist Goals and Goal Conflict

Committee at the next meeting. The final view of the Committee will be communicated to you.

On completion of the research you must submit a brief report of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely



Professor John Foreman
Chair of the UCL Research Ethics Committee

Cc: Samuel Russ

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