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# Unavoidable Stressful Client Situations: Sources of Social Support on Clinical Psychologists' and Counsellors' Psychological Well-Being

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**Abstract.** The increasing demand for mental health services in Singapore makes it important to understand how the stressful nature of clinical psychologists' and counsellors' professions affect their psychological well-being. The study explored how different sources of social support (clinical supervisor, coworker, nonprofessional) predict clinical psychologists' and counsellors' exhaustion, stress, depression, and anxiety levels during stressful client sessions. Participants (78 trainee/professional clinical psychologists and counsellors;  $M_{age} = 39.73$  years old,  $SD = 10.83$ ) recalled a stressful client situation before completing online questionnaires. Results from stepwise multiple regression indicated that, partially aligned with the hypothesis, social support from coworker predicted lower exhaustion but not on other aspects of psychological well-being. Contrary to the hypothesis, social support from clinical supervisor and nonprofessional did not predict psychological well-being. These findings suggest that organizations may support clinical psychologists and counsellors by enhancing the coworker social support system. Coworkers showing care and concern (i.e., social comfort) or giving assurance with regards to competencies and abilities (i.e., social encouragement) to clinical psychologists and counsellors in Singapore might be helpful for their psychological well-being.

**Keywords:** Social Support, Exhaustion, Clinical Psychologists, Counsellors.

## Introduction

The increased demand for mental health services in Singapore makes it pertinent to understand how it affects the psychological well-being of mental health professionals, particularly clinical psychologists and counsellors (Cushway et al., 1996). Social support has been emphasized in the field of mental health to be an important resource for coping with stress and anxiety (Bettney 2017; Helgeson, 1993; Schwartz-Mette, 2009; Wicks, 2008). However, there is still a limited understanding of the effects of the social support provided by different sources (i.e., clinical supervisors, coworkers, and nonprofessionals) on the psychological well-being of clinical psychologists and counsellors. Additionally, limited research has been carried out to examine the underlying mechanisms (social encouragement or social comfort) of the healthful impacts of social support. The present study therefore aimed to explore how the social support from different sources predict the psychological well-being of clinical psychologists and counsellors.

## Compromised Well-Being among Clinical Psychologists and Counsellors

There has been a growing demand for mental health services in Singapore (Subramaniam et al., 2019) partly due to the increase in lifetime prevalence of mental illness in Singapore (i.e., 12% in 2010 to 13.9% in 2016; Singapore Mental Health Study, 2016). Mental health therapeutic work is demanding regardless of one's therapeutic orientation or experience (Hayes, 2004). Mental health professionals, particularly psychologists and counsellors, work in emotionally demanding environments with clients of various types and intensity of mental health problems (Moore & Cooper, 1996; Lawson & Myers, 2011; Maslach & Goldberg, 1998; Richards, Campenni, & Muse-Burke, 2010). As such, compromised psychological well-being is evident in literature sampling both clinical psychologists and counsellors (Moore & Cooper, 1996; Rabin et al., 1999; Rossler, 2012; Volpe et al., 2014). While some psychiatrists provide long-term psychotherapy on top of conducting brief medical assessments or prescribing medications, clinical psychologists and counsellors provide regular, longer, and comprehensive mental and behavioral health care (American Psychological Association, 2008; Hall et al., 2015), which can be relatively more stressful. They often deal with stressful client situations, including clients' suicidal tendencies and fluctuating emotions (Knox et al., 2006; Kumary & Baker, 2008; Lee et al., 2011; Schwartz-Mette, 2009).

The stress clinical psychologists and counsellors experience has been linked to negative outcomes, including depression (Gilroy et al., 2002), anxiety, exhaustion (Radeke & Mahoney, 2000), self-esteem difficulties (Butler & Constantine, 2005), somatic problems (Gilroy et al., 2002), hopelessness, inadequacy, self-doubt, fear (Norcross & Guy, 2007; Veilleux, 2011), and questioning their own professional competence (Colli et al., 2014). As a result of stress, some therapists experience Distressing

Practice – feeling chronically bored or anxious, using avoidant coping to deal with difficult client situations (Zeeck et al., 2012). The negative consequences of stress undermine therapists' attention, decision-making, and capacities to empathize with and support clients (Enochs & Etzbach, 2004; Lambert & Barley, 2001; Renjilian et al., 1998; Skosnik et al., 2000; Starcke & Brand, 2012). It would be interesting to explore how colleagues (e.g., supervisors and coworkers) and nonwork close family and friends (e.g., nonprofessionals; APA, 2008) can identify the warning signs of compromised psychological well-being (e.g., exhaustion, stress, depression, and anxiety) and hopefully tackled at an early stage by colleagues.

### **Social Support as a Resource**

Social support can be an effective strategy to support mental health professionals' psychological well-being. It provides positive assistance and support for individuals (Harvey, 2014; Shorey & Lakey, 2011; Thoits, 2011) to cope better with strains and reduce negative outcomes like stress and depression (e.g., Kossek et al., 2011; Shorey & Lakey, 2011) through emotional comfort, guidance, and motivation (House, 1981).

For niche professions like clinical psychologists and counsellors, social support may come from supervisors, coworkers, and nonprofessional family or friends (e.g., Armstrong et al., 2015; Watson et al., 2019; Wise et al., 2019). All three sources of social support affect depression, burnout, job and life satisfaction to different extents (Yildirim & Aycan, 2008). For example, social support from supervisors and coworkers had stronger associations with psychological well-being and psychological adaptation at work than support from nonprofessionals (Greenglass et al., 1996). It is important to note that while not all mental health practitioners have clinical supervisors, all mental health practitioners must complete a minimum number of therapy hours under clinical supervision to become licensed to practice across countries (American Counselling Association, 2014; Tracey, 2006).

**Social Support from Clinical Supervisor.** Clinical supervisors provide social support to supervisees by guiding them to acquire and hone their competencies through client activities in workplace settings or in simulated environments (Australian Psychology Accreditation Council Standards, 2019). Although supervisors also monitor and evaluate supervisees' professional (e.g., client's progress) and personal (e.g., self-reflection) development, this does not rule out the care and support supervisors provide (Corey et al., 2010). With the social support from supervisors, supervisees feel valued and respected (Lee & Ashforth, 1996) and intrinsically motivated to meet challenges (Lee et al., 1996) and makes the job more enjoyable (Lambert, 2004). Conversely, with nonsupportive supervisors, supervisees feel exhausted (Geuskens et al., 2012), less

achieving, and dissatisfied with jobs (Adriaenssens et al., 2015; Hamama, 2012).

**Social Support from Coworker.** Coworkers may provide emotional support (e.g., concern), instrumental assistance (e.g., helping with tasks; Liaw et al., 2010; Ng & Sorensen, 2008), and guidance and information to cope effectively with workplace stress (Bakker et al., 2005). Coworkers may share their experience dealing with job stress (Lambert et al., 2010) and provide listening ears for venting (Cherniss, 1980). Research has shown that social workers who received social support from colleagues had a reduced degree of burnout (Hamama, 2012). In contrast, a low level of coworker support was associated with exhaustion (Sundin et al., 2011; Theorell et al., 2012).

**Social Support from Nonprofessional.** Nonprofessional, such as family and friends, are able to provide social support in the form of an escape opportunity, a safe haven from work stressors and a more balanced life (Cords & Dougherty, 1993). Family and friends give information and guidance on how they may deal with work issues from a nonprofessional perspective or just provide a pair of listening ears (Lambert et al., 2010). Such support is useful for health professionals, for instance hospital nurses who receive a higher level of social support from nonprofessional peers and family reported lower levels of burnout and compassion fatigue (Ariapooran, 2014).

Different sources of social support have different functional values in work-related psychological adaptation. Social support from clinical supervisors can provide direct and effective guidance to deal with stressful client situations as compared to social support from coworker and nonprofessional. Coworkers are better able to understand stressful client situations better than nonprofessionals, whereas nonprofessionals provide a safe haven to disengage emotionally from stressful client situations.

### ***The Effects of Social Support***

Social support provided during stress might have either an encouraging effect, comforting effect, or a mixture of both. According to literature, social support brings on positive effects (e.g., healthful benefits) in times of stress (Teoh & Hilmert, 2018). For a more holistic representation, both the encouraging and comforting effects were considered in the operationalization of social support in the present study.

**The Social Encouraging Effect.** The social encouraging effect is grounded in behavioral literature, where social support motivates individuals to act constructively in times of stress (Wills, 1985). In a study by Cicero and colleagues, the social encouragement effect of social support was evidenced among Italian patients diagnosed with different types of cancer (e.g., breast, colorectal; Cicero et al., 2009). Participants in the study

who reported feeling supported demonstrated lesser resignation and passive acceptance. Instead, they were more likely to show greater fighting spirit and reframe their cancer as a challenge and actively participate in therapy (Cicero et al., 2009). The social encouragement effect benefits health by putting forth effort in managing (and potentially increasing the chance of removing) the source of stress.

**The Social Comfort Effect.** The social comfort effect is grounded in the stress-buffering hypothesis (Cohen & Wills, 1985), where social support comforts individuals under stressful conditions, attenuating the possible consequences of stress on an individual's health. Perceiving that others can and will provide resources or support may help individuals reframe their negative perceptions of stressful situations and decrease the arousal level. Social support may then be able to comfort stressed individuals and relieve physiological symptoms, like alleviating heightened blood pressure and heart rate. This benefits health because reducing prolonged exertion on the cardiovascular system lowers the risk for cardiovascular diseases.

### **The Present Study**

The present study aimed to explore how the social support from different sources predicts the psychological well-being of clinical psychologists and counsellors. We examined psychological well-being in terms of stress and exhaustion as well as more severe symptoms, including depression and anxiety. Keeping in mind that stress can be considered the first sign of compromised psychological well-being before more severe symptoms can set in (Roberts, 2020), we predicted that after a stressful client situation, social support from all the three sources would predict a low level of stress.

## **Method**

### **Design and Participants**

The study adopted a cross-sectional correlational research design. Participants were 78 mental health professionals between the ages of 27 and 72 years ( $M_{age} = 39.73$  years old,  $SD = 10.83$ ), spending an average of 2 to 40 hours in clinical practice per week. There were 25 clinical psychologists and trainees (21 females; 4 males) and 53 counsellors and trainees (38 females; 13 males; 2 unspecified gender) (see Table 1). We invited trainees to participate in the study as they carry out similar work as practicing clinical psychologists and counsellors (Association of Clinical Psychologists UK, 2020).

**Table 1***Descriptive Statistics of the Sample Characteristics (N = 78)*

Demographic Variable	Categories	<i>n</i>	Percentage
Gender	Women	59	75.64
	Men	17	21.80
	Unspecified	2	2.56
Occupation	Clinical Psychologist ( <i>M<sub>age</sub></i> = 32.04 years old, <i>SD</i> = 6.11)	25	32.05
	Counsellor ( <i>M<sub>age</sub></i> = 43.36 years old, <i>SD</i> = 10.71)	53	67.95
Occupation Status	Practitioners	56	71.79
	Trainees	20	25.64
	Did not indicate	2	2.56
Relationship Status	Single	16	20.51
	In a committed relationship	17	21.80
	Engaged	2	2.56
	Married	37	47.43
	Divorced	6	7.70
Nationality	Singaporean	74	94.88
	Malaysian	2	2.56
	Portuguese	1	1.28
	Mainland Chinese	1	1.28

The inclusion criteria include (a) trainee clinical psychologists – students in the Master of Psychology (Clinical) programs in Singapore; (b) practicing clinical psychologists – professionals practicing as a clinical psychologist (e.g., seeing clients or running own clinics) in Singapore; (c) trainee counsellors – students in the Master of Counselling programs in Singapore; or (d) practicing counsellors – professionals practicing as a counsellor (e.g., seeing clients or running own clinics) in Singapore. We recruited participants through the Singapore Psychological Society, Singapore Association for Counselling, institutions offering the Master of Psychology (Clinical) and Master of Counselling programs in Singapore, social media (e.g., LinkedIn, Facebook), and word of mouth.

### Materials

***Stressful Client Experience Recall.*** The stressful client experience recall required participants to recall frequently encountered stressful sessions with clients before completing the subsequent questionnaires. They were asked to select one theme from a list that frequently made them feel stressed in their work, e.g., “client’s resistance to treatment” and “client’s suicidal tendencies.” If these themes did not apply to them, they were given the option to provide their own. Next, they were asked to briefly describe a specific encounter of the theme they had selected. To determine how stressed they felt when the incident happened, they rate how stressed they felt on a six-point Likert-type scale (0 = *Not at All*, 5 = *Very Much*). See

Table 2 for the type of stressful themes endorsed by participants of the present study.

**Table 2**

*The Types of Stressful Themes Endorsed by the Study Participants (N = 78)*

Stressful Themes	Frequency	Percentage
Client's resistance to treatment	27	30.68
Client's suicidal tendencies	13	14.77
Client's reluctance to think about therapy during/between sessions	9	10.23
Client's fluctuating emotions	8	9.09
Client's negative evaluation of sessions	6	6.82
Difficulty establishing therapeutic alliance with client	6	6.82
Client's inconsistent attendance	1	1.14
Other themes: Mainly in couple counselling when one partner refuses to see or finds it hard to understand what the other is going through	1	1.14
Other themes: Thinking I'm not competent enough to help my clients with their therapy goals	1	1.14
Other themes: Clients who come from marginalized communities	1	1.14
Other themes: Couples' stuckness in their relationship	1	1.14
Other themes: Parental disengagement	1	1.14
Other themes: Clients (or parents) unable to come for sessions	1	1.14
Other themes: Client's repeated negative thinking after various sessions	1	1.14
Other themes: Emotional dysregulation	1	1.14

### ***Social Support Scale***

For the purposes of this study, overall social support was measured using the Social Support Scale that was adapted and combined from the Perceived Social Support Scale (Teoh, 2015) and the Smith Relaxation States Inventory 3 (Smith, 2005). The scale consisted of three subscales. The first subscale (i.e., Perceived Social Support subscale), adapted from Teoh (2015), measured how *supported* and *satisfied* participants felt (two items). The second subscale (Social Encouragement subscale), also adapted from Teoh (2015), measured how *socially encouraged* participants felt (11 items). The third subscale (Social Comfort subscale), developed by Smith (2005), measured how *socially comforted* participants felt (11 items). We adapted both the social encouragement and social comfort subscales to fit the context of mental health professional experiences. Modified items include “*The experimenter instilled hope in me when I felt like giving up on the task*” to “*He/She instilled hope in me when I felt like giving up on the client/case.*”

Participants rated the 24 items in terms of how they felt when they experienced the stressful client experience using a six-point Likert-type scale (0 = *Not at All/Not Applicable*, 5 = *Very Much*). Participants completed the scale three times – one for each source of social support, or

specifically clinical supervisor, coworker, and nonprofessional friend/family member. This combined measure had not been previously used before. Nonetheless, the subscales had high internal consistency in the present study (ranging between .75 and .97). We averaged the scores of all the items of the scale for the overall level of social support. We also averaged the scores of each subscale to obtain the scores for perceived social support, social encouragement, and social comfort respectively. Greater scores in these variables reflect higher levels of the construct measures.

At the end of this questionnaire, participants indicated the type of clinical supervisory support they had in mind from two options provided – clinical/casework supervision (e.g., discussing directly about client issues such as assessment, diagnosis, treatment options, medication support) or managerial supervision (e.g., discussing the goals of the organisation, training, target setting, disciplinary issues, client load).

***Exhaustion Subscale Adapted from Oldenburg Burnout Inventory.*** We measured exhaustion with the Exhaustion subscale from the Oldenburg Burnout Inventory (Demerouti & Nachreiner, 1998). Participants rated the eight items of this subscale, such as “When I work, I usually feel energized,” on a four-point Likert-type scale (1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Agree*, 4 = *Strongly Agree*) based on how they generally feel and think about their role as a mental health professional. This subscale could be discriminated from measures of mental fatigue and satiation (Plath & Richter, 1984) and was significantly related to mental fatigue (Demerouti et al., 2001). The Exhaustion subscale had a Cronbach's alpha value of .82 in the present study. After reverse scoring relevant items, we averaged the responses, with higher scores reflecting a higher level of exhaustion.

***Depression, Anxiety and Stress Scale – 21 items.*** We used this 21-item instrument to assess the levels of depression (7 items), anxiety (7 items), and stress (7 items; Lovibond & Lovibond, 1995). Sample items for each of the symptoms include “I felt down-hearted and blue” and “I found it difficult to relax.” Participants considered each item based on the stressful client experience indicated above and rated their responses on a four-point Likert-type scale (0 = *Never*, 1 = *Sometimes*, 2 = *Often*, 3 = *Almost Always*). The scale had good construct validity (Henry & Crawford, 2005) and was normalized based on a large non-clinical adult sample (Henry et al., 2005). The ratings of depression, anxiety, and stress had Cronbach's  $\alpha$  values of .66, .77, and .67 respectively in the present study. We computed average scores for each subscale, with greater scores reflecting higher levels of depression, anxiety, and stress.

***Demographics Questionnaire.*** The demographic information collected in the study included gender, age, nationality, highest educational



degree attained, occupation, and relationship status. Participants indicated the average number of hours spent in clinical practice per week, the average number of hours spent in clinical placement per week, and the duration of clinical experience including postgraduate placements.

### **Procedure**

After receiving an ethics clearance, we invited participants to complete an online survey via Qualtrics. After reading the information sheet, participants gave an informed consent by choosing the “Agree” button. Those who chose “Do not agree” did not give a consent and were directed out of the survey.

Next, participants completed the "Stressful Client Experience Recall" task. Keeping the recalled theme and situation in mind, they next completed the questionnaires above in a randomized order. Lastly, they completed the demographic form. The estimated duration of the study was 15 minutes.

## **Results**

### **Preliminary Analyses**

To identify potential covariates that might affect the study variables and the interpretation of the findings, we performed correlation analyses to test the associations between age and the study variables. Given the nonsignificant correlations among them, age was not included as a covariate in the main analyses (see Table 3). We also performed ANOVA to explore the effects of gender on all the study variables. There were no significant differences between men and women on the study variables, so gender was not included as a covariate.

**Table 3***The Correlation Coefficients of the Relationships between Age and the Study Variables (N = 78)*

	Age	1	2	3	4	5	6	7	8	9	10
DASS-21											
1. Depression	-.44**										
2. Anxiety	-.28*	.64**									
3. Stress	-.34**	.77**	.71**								
Exhaustion Subscale											
4. Exhaustion	-.36**	.46**	.38**	.49**							
Social Support Scale - Supervisor											
5. Overall Social Support	-.17	.07	.01	.03	.01						
6. Perceived Social Support	-.20	.06	.05	.01	.04	.81**					
7. Social Encouragement	-.27*	.15	.09	.10	.07	.95**	.82**				
8. Social Comfort	-.03	-.02	-.08	-.05	-.06	.93**	.63**	.78**			
Social Support Scale - Coworker											
9. Overall Social Support	.17	.05	.05	.09	-.21	.41**	.20	.33**	.47**		
10. Perceived Social Support	.17	.11	.15	.18	-.12	.08	.08	.10	.05	.79**	
11. Social Encouragement	.07	.17	.15	.19	-.12	.34**	.22*	.35**	.29**	.92**	.81**
12. Social Comfort	.23*	-.07	-.05	-.03	-.26*	.46**	.17	.30**	.61**	.91**	.56**
Social Support Scale - Nonprofessional											
13. Overall Social Support	.11	.15	.02	.12	-.04	.28*	.14	.20	.36**	.49**	.30**
14. Perceived Social Support	.00	.22	.09	.14	.02	.20	.26*	.21	.15	.29**	.31**
15. Social Encouragement	.05	.20	.06	.18	-.04	.24*	.16	.19	.27*	.45**	.31**
16. Social Comfort	.19	.07	-.04	.04	-.06	.32**	.08	.18	.45**	.53**	.26*

*The Correlation Coefficients of the Relationships between Age and the Study Variables (N = 78) (cont.)*

	11	12	13	14	15	16
Social Support Scale - Coworker						
12. Social Comfort	.69**					
Social Support Scale - Nonprofessional						
13. Overall Social Support	.43**	.49**				
14. Perceived Social Support	.34**	.18	.84**			
15. Social Encouragement	.45**	.40**	.97**	.82**		
16. Social Comfort	.38**	.60**	.96**	.73**	.85**	

*Note.* \*  $p < .05$  (2-tailed). \*\*  $p < .01$  (2-tailed). DASS-21 = The Depression, Anxiety and Stress Scale – 21 Items.

In the Stressful Client Experience Recall task, participants rated the situation as stressful ( $M = 3.88$ ,  $SD = 0.81$ ). Additionally, all participants indicated that the type of clinical supervisory support they had in mind was related to clinical/casework supervision rather than managerial supervision. The means and standard deviations of the variables are presented in Table 4.

**Table 4**

*Means and Standard Deviations of the Predictor Variables, Mediating Variables, and Outcome Variables (N = 78)*

Variables	<i>M</i>	<i>SD</i>	Range
<b>Predictor Variables</b>			
Overall Social Support from Clinical Supervisor	2.98	1.17	0.00 – 5.00
Overall Social Support from Coworker	3.02	1.04	0.00 – 4.92
Overall Social Support from Nonprofessional	2.63	1.34	0.00 – 5.00
<b>Sub-Predictor Variables</b>			
Clinical Supervisor			
Social Encouragement Effect	3.34	1.27	0.00 – 5.00
Social Comfort Effect	2.49	1.22	0.00 – 5.00
Coworker			
Social Encouragement Effect	3.27	1.09	0.00 – 5.00
Social Comfort Effect	2.62	1.19	0.00 – 5.00
Nonprofessional			
Social Encouragement Effect	2.74	1.42	0.00 – 5.00
Social Comfort Effect	2.40	1.37	0.00 – 5.00
<b>Outcome Variables</b>			
Exhaustion	2.30	0.42	1.00 – 3.38
Stress	0.48	0.36	0.00 – 2.00
Depression	0.55	0.36	0.00 – 1.57
Anxiety	0.43	0.39	0.00 – 1.71

### **Main Analyses**

We performed multiple regression analyses to examine the extent to which different sources of social support predict mental health professionals' psychological well-being. In each standard multiple regression analysis, the predictors were overall social support from clinical supervisor, social support from coworker, and social support from nonprofessional (24 items for each source of social support). Mental health

professionals' levels of exhaustion, stress, depression, and anxiety each were entered as the outcome variable.

**Assumptions.** Before we performed the analyses, we examined the assumptions of multiple regression. The data satisfied the assumptions of multicollinearity, homoscedasticity, and independence of residuals. The Shapiro-Wilk test showed that all variables significantly deviated from a normal distribution. However, since ordinary least square regression is robust against the violation of normality assumptions (Tabachnick & Fidell, 2015), no transformation of variables was performed. The data had two univariate outliers. We subsequently performed two sets of main analyses using the data with outliers and the data without outliers. As the results from both the data sets were similar, we reported the results that were based on the data without outliers.

Main Analyses Results (see Table 5).

**Table 5**

*The Summary of the Multiple Regression Analyses (N = 78)*

	R-Square	df	F	p		
Exhaustion	.06	3, 74	1.51	.22		
Stress	.02	3, 74	.39	.76		
Depression	.03	3, 74	.66	.58		
Anxiety	.00	3, 74	.07	.98		
		B	SE B	$\beta$	t	p
Exhaustion						
Social Support from Clinical Supervisor		.04	.05	.11	.85	.40
Social Support from Coworker		-.12	.06	-.29	-2.08	.04*
Social Support from Nonprofessional		.02	.04	.07	.52	.61
Stress						
Social Support from Clinical Supervisor		-.01	.04	-.02	-.16	.87
Social Support from Coworker		.02	.05	.05	.34	.74
Social Support from Nonprofessional		.03	.04	.10	.76	.45
Depression						
Social Support from Clinical Supervisor		.01	.04	.04	.35	.73
Social Support from Coworker		-.02	.05	-.05	-.35	.72
Social Support from Nonprofessional		.04	.04	.17	1.25	.22
Anxiety						
Social Support from Clinical Supervisor		-.00	.04	-.01	-.07	.94
Social Support from Coworker		.02	.05	.06	.43	.67
Social Support from Nonprofessional		-.00	.04	-.01	-.05	.96

Note. \*  $p < .05$

**Exhaustion.** With exhaustion as the outcome variable, a nonsignificant model emerged,  $F(3, 74) = 1.51, p = .22$ . Nonetheless, in line with our hypothesis, social support from coworker significantly predicted a lower level of exhaustion,  $\beta = -.29, t(74) = -2.08, p = .041$ . However, social support from clinical supervisor,  $\beta = .11, t(74) = 0.85, p = .40$ , and social support from nonprofessional,  $\beta = .07, t(74) = 0.52, p = .61$ , did not predict exhaustion.

**Stress.** Utilizing the stress subscale of the DASS-21 as the outcome variable, a nonsignificant model emerged,  $F(3, 74) = 0.39, p = .76$ . The results showed that social support from clinical supervisor,  $\beta = -.02, t(74) = -0.16, p = .87$ , coworker,  $\beta = .05, t(74) = 0.34, p = .74$ , and nonprofessional,  $\beta = .10, t(74) = 0.76, p = .45$ , did not predict stress.

**Depression.** With depression as the outcome variable, a nonsignificant model was found,  $F(3, 74) = .39, p = .76$ . The results showed that social support from clinical supervisor,  $\beta = -.02, t(74) = -0.16, p = .87$ , coworker,  $\beta = .05, t(74) = 0.34, p = .74$ , and nonprofessional,  $\beta = .10, t(74) = 0.76, p = .45$ , did not predict depression.

**Anxiety.** With anxiety as the outcome variable, a nonsignificant model was noted,  $F(3, 74) = .66, p = .58$ . Social support from clinical supervisor,  $\beta = .04, t(74) = .35, p = .73$ , coworker,  $\beta = -.05, t(74) = -.35, p = .72$ , and nonprofessional,  $\beta = .17, t(74) = 1.25, p = .22$ , did not predict anxiety.

## Discussion

Although the present study found a broad pattern of null results which limits the strength of conclusions that can be drawn, key findings together with the theoretical and practical implications are discussed as follows.

### Key Findings

Consistent with the hypothesis, social support from coworker predicted lower exhaustion. However, contrary to the hypothesis, social support from coworker did not predict lower stress, depression, and anxiety. Also, social support from clinical supervisor and nonprofessional did not predict any of the outcome measures of psychological well-being (i.e., exhaustion, stress, depression, and anxiety).

### Theoretical Implications

#### *The Effects of Three Sources of Social Support on Psychological Well-Being*

The present study revealed that social support from clinical supervisor did not predict any of the outcome measures of psychological well-being. This is in contrast to what was initially hypothesized and what was suggested in the literature (e.g., Kossek et al., 2011; Lambert et al., 2017).

Such findings could be due to the dual roles of supervisors. Supervisors can be seen as both a supportive figure and a significant source of stress (Renfro-Michel & Sheperis, 2009). Undeniably, a supportive supervisor may nurture supervisees for their professional and personal development and establish a caring supervisory relationship (Corey, 2010). However, supervisors can also be a source of stress. This is likely because supervisors' "quasi-parental" role in the supervisory relationship makes supervisees feel the evaluation apprehension (Cushway, 1992; Jones & Thompson, 2017). The tension arises from personality clashes between both parties may further exacerbate the situation (Cushway, 1992). Apart from the overseas findings (e.g., Renfro et al., 2009), evidence from Singapore on the supervisor-supervisee dynamics has been limited. It is likely that driven by the higher power distance in the culture of Singapore (Hofstede, 2001), supervisees may overemphasize the authority of supervisors, which then dampening the perceived supportiveness from supervisors. We urge for more research to investigate the dynamics between supervisors and supervisees in Singapore.

As hypothesized, coworker support predicted a lower level of exhaustion, a finding that was in line with the literature (e.g., Liaw et al., 2010). Jones and Thompson (2017) illustrated that social support from coworkers play an important role in combating stress as coworkers, who have gone through similar experiences, could empathize with us. From Jones and Thompson's qualitative interviews, participants who received coworker support experienced an increase in self-confidence and overcame irrational feelings of not being able to cope in their job role. This possibly enabled them to perceive their situation more objectively, which then attenuates negative reactivity, eventually leading to reduced fatigue (Glomb et al., 2011).

The present study revealed that social support from nonprofessionals did not predict any of the outcome measures, findings that were contrary to our hypotheses. It is important to note that the literature has acknowledged the value of social support from nonprofessionals, where it provides individuals with a safe haven beyond the workplace (Cords & Dougherty, 1993). However, our findings suggested that this might not be sufficient in enhancing psychological well-being especially in the face of stressful client situations. Also, given that coworker support was associated with reduced exhaustion in our study, our participants might have been overly engaged in stressful client situations (high physical and mental energy devoted). As such, it was difficult for them to disengage emotionally with the help of nonprofessional support. On the other hand, social support from coworkers likely provides more relevant and appropriate support. Coworkers give practical guidance and information, which helps managing the stressors directly (Lambert et al., 2010), and provide professional emotional support, like therapeutic listening and comfort, which is useful in emotional regulation (Cherniss, 1980).

### ***Exhaustion as the First Sign of Compromised Psychological Well-Being***

As stress is the first sign of compromised psychological well-being (Roberts, 2020), we predicted social support to alleviate stress. However, our findings showed social support alleviated the feeling of exhaustion, suggesting that exhaustion (instead of stress) is the first sign of mental health struggle. Stress is a normal physiological and mental response to demanding circumstances, and it decreases when stressors disappear (Roberts, 2020). Exhaustion, on the other hand, is a state of lack of energy and a feeling of emotional depletion (Watkins et al., 2015).

Literature has argued that stress and exhaustion are mutually reinforcing. One school of thought (e.g., the Transactional Model of Stress; Lazarus & Folkman, 1984; and Allostatic Load Theory; McEwen & Wingfield, 2003) argues that stress induces and escalates exhaustion (Bauernhofer et al., 2018; Salvagioni et al., 2017). Another school of thought (e.g., Stressor Perception Hypothesis; De Lange et al., 2004), on the contrary, argues that the gradual buildup of exhaustion decreases one's ability to cope with stress, which results in an even higher level of stress.

The present study adds to the competing literature between stress and exhaustion and suggests that exhaustion can be considered the first sign of compromised psychological well-being among mental health professionals in the Singaporean context. This serves as a reliable first line of intervention at detecting and preventing more severe symptoms like depression and anxiety from setting in.

### **Practical Implications**

Coworker social support appears to be an effective, cost-efficient, and extensively applicable strategy that can better support clinical psychologists and counsellors as the demands for mental health services continue to rise in Singapore.

Organizations can consider designing healthy coworker systems to support mental health professionals who might be more prone to compromised psychological well-being. For example, peer trainings can include psychoeducation about the common emotional struggles clinical psychologists and counsellors might experience and the importance of coworker support to them. Note that continued registration as a clinical psychologist or counsellor in Singapore requires at least 30 hours per year and 50 hours every two years of continual professional development respectively (e.g., attending professional workshops; Singapore Psychological Society, 2020; Singapore Association for Counselling, 2020). The peer-focused training suggested above can be offered as a professional development workshop.

Although our study showed that coworker support was associated with reduced exhaustion, it does have its limitation. It is important to note that some mental health professionals may feel ashamed to admit their struggle, thinking that others might judge them negatively (Garelick, 2012). In this case, they might become less comfortable disclosing their problems



to coworkers. For such mental health professionals, organizations should explore other ways (e.g., accessibility to anonymous personal therapy) to support them. Further consideration can also be taken from Yue and Varunee's (2015) paper, in which they suggested a range of holistic strategies across the ecological system (i.e., micro, meso, and macro levels) in advocating for more attention and action on care for mental health professionals' well-being.

### **Limitations and Suggestions for Future Studies**

While the findings of the present study provided partial support for the main hypothesis, several limitations of the study must be considered when interpreting the findings. First, the sample of the study was small ( $N = 78$ ), with a response rate of approximately 15.38% in relation to the small numbers of registered clinical psychologists (i.e., 129) and counsellors in Singapore (i.e., 378). This is consistent with other studies of a similar nature and population, where they also had low sample sizes despite having large pools of psychologists in their countries. For example, there was a 29.5% response rate in a study in Finland (Kuittinen et al., 2014) and between 0.75% and 37.5% in the studies conducted across various states in Australia (e.g., Di Benedetto & Swadling, 2014; Finlay-Jones et al., 2015). Although universally similar across the world, it must be acknowledged that this is a limitation that restricts the conclusions that can be drawn. Second, clinical psychologists who partook in the study might differ greatly in attitudes and psychological states from those who did not, creating a response bias. For instance, the sample could have been overrepresented or underrepresented by burnt-out participants. Considering the mean and standard deviation of the exhaustion level in the present study ( $M = 2.30$  on a scale from 1 to 4,  $SD = 0.42$ ), although our participants were at a neutral level of exhaustion, there was a low variability. A sample with more variations in the level of exhaustion might be more helpful in addressing the research question. Third, the means for stress, depression, and anxiety appear to be very low (Table 5), which would limit the ability to detect effects on the outcome variables. Additional limitations to consider include multiple testing and a broad pattern of null effects.

Future studies could consider examining the mechanisms of social support to shed light on the ways social support can be provided to better support mental health professionals. Specifically, exploring the underlying mechanisms of how social support affects psychological well-being is crucial as it sheds light on how social support should best be provided. According to the literature, social support provided during stress might have an encouraging or comforting effect, both of which have been found to bring on positive effects (e.g., healthful benefits) in times of stress (Teoh & Hilmert, 2018). The social encouragement effect is grounded in behavioral literature, where social support motivates individuals to act constructively in times of stress (Wills, 1985). The social comfort effect is grounded in the stress-buffering hypothesis (Cohen & Wills, 1985), where social support

comforts individuals under stressful conditions, attenuating the possible consequences of stress on an individual's health.

Additionally, future research could also consider including former mental health professionals who had recently chosen to leave the profession (likely due to burnout) to have a more holistic understanding of the effect of social support on their mental health. Next, utilising a qualitative design to provide a deeper perspective of how mental health professionals perceive and attach meanings to the social support provided by various sources. Lastly, future research might consider a deeper examination of exhaustion as an outcome.

### **Conclusion**

The increasing demand for mental health services in Singapore, coupled with the stressful nature of the profession, warrants efforts to understand how stressful clients' situations affects the psychological well-being of mental health professionals. Effective ways can then be sought to better support them. The present study found that social support from coworkers predicted lower exhaustion. Therefore, organisations may support mental health professionals through enhancing the coworker social support system. With better support and optimal working environments, clinical psychologists and counsellors can be prepared to provide better mental healthcare for their clients.

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### **Availability of data and material**

Data will be made available upon reasonable request.

### **Conflict of Interest**

The authors declare that they have no conflict of interest.

### **Author's contributions**

Yun Ting Yip: Conceptualization, data curation, formal analysis, methodology, resources, writing – original draft, writing – review & editing; Ai Ni Teoh: Conceptualization, formal analysis, methodology, supervision, writing – original draft, writing – review & editing; Poi Kee Low: data curation, resources, writing – review & editing.

### **Informed Consent**

All participants gave an informed consent by choosing the “Agree” button after reading the information sheet.

### Ethics Approval

This study has received ethical approval from the University's Human Research Ethics Committee (Approval Number: H8247)

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