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CHAPTER 1

Clinical Psychology in Ireland: What Empirical Studies of Professional Practice Tell Us

Alan Carr

SUMMARY

This chapter briefly sketches the historical development of clinical psychology in Ireland and against this backdrop summarizes key findings from the 5 studies described in the remainder of this book. Clinical psychology has evolved in Ireland over the past 40 years from a profession with only a handful of members and a circumscribed role to one with over 300 professionals with complex and diverse roles. The first professional university based training programmes were set up in the late 1970s. The output from these continues to fail to meet the demand for qualified clinicians. Clinical psychologists are employed in three main areas: child mental health services; adult mental health services; and physical and intellectual disability services. The results of surveys of clinical psychologists in Ireland conducted by Alan Carr in 1993 and Alan Doran and Alan Carr in 1995 underline clinical psychologists' flexibility in being able to fulfil complex roles in diverse organizational contexts within the health boards and other health care agencies. The most salient finding of a 1998 study of the role of clinical psychologists in child protection reported by Elaine O'Brien, Sean Carey and Alan Carr is that clinical psychologists have a multifaceted role in child protection work which is more complex than that documented in previous international studies. In a survey of stress among recently qualified psychologists and psychologists in clinical training Claire Donohoe highlights the stressful

nature of the role of the clinical psychologist and the training process. Deirdre Dunne and Alan Carr in a survey of harassment of clinical psychologists by clients found that a quarter of psychologists considered that they had been sexually harassed, a third that they had been physically harassed and two thirds that they had been verbally harassed by clients. As a whole the studies reported in this volume provide empirical evidence for the important contribution that clinical psychology is making to health care in Ireland and the unique demands that psychologists face during training and within professional practice. Our results have clear implications for the development of the profession. Clinical psychologists as a highly trained yet numerically small group of professionals may be most usefully deployed within the health service through adopting a *shared care* approach and taking a *consultant role*. With increased numbers clinical psychology could make significant contributions to other areas such as older adult care, paediatrics, coronary care, drug abuse, prevention programmes, and palliative care. This highlights the need to increase the number of clinical psychologists being trained. Because of the stressful nature of clinical psychologists' roles during and following professional training there is a need to keep work and training role demands to realistically manageable proportions and to develop support and supervision structures to facilitate stress management during training and within professional practice. Because of the prevalence of negative sexual, physical and verbal interactions with clients, there is a need for training programmes, policies and practices to help psychologists manage harassment by clients in a professional manner. There is also a need to promote the importance of continuing professional development and training in child protection since this is one of the important factors that promotes role satisfaction and prevents professional burnout among psychologists in this area.

INTRODUCTION

The aim of this chapter is offer a distillation of key findings from the 5 studies

described in Chapters 2 through 6. To place these findings in context, a brief overview of the development of clinical psychology services and clinical psychology training will be offered.

THE EMERGENCE OF CLINICAL PSYCHOLOGY IN IRELAND

Clinical psychology in Ireland is a relatively young profession, but one with a long history which has been well documented (Brady, 1990; Brady & McLoone, 1992; Psychological Society of Ireland, 1975). Scholarship in psychology can be traced back to the early Christian era when philosophical studies flourished in Irish centres of learning. In Ireland psychology was seen as a philosophical discipline for many years. The word *psychology* first appeared in the title of an Irish academic post in 1909 when a Chair of Logic and Psychology was instituted at University College Dublin. The first professional psychology course in Northern Ireland was established in The Queen's University of Belfast in 1947, and in the Republic of Ireland at University College, Dublin (UCD) in 1958. This professional Diploma in Psychology Course set up in UCD in that year was open to honours graduates who brought to the course the experience gained in their various professions including teaching, medicine, and the social and natural sciences. This ensured that the first graduates and founders of the profession in Ireland would be mature and experienced people. The course included both academic tuition and practical training. Over the next 15 years, undergraduate courses in psychology were established at Trinity College, Dublin (TCD); University College, Cork; University College, Galway; and University College, Dublin. These four universities offer honours degrees which confer eligibility for graduate memberships of The Psychological Society of Ireland and the British Psychological Society. In Northern Ireland, psychology courses are offered at The Queen's University, Belfast, and at the Coleraine, Derry and Jordanstown campuses of the University of Ulster.

Clinical Psychology Services in Ireland

The first psychological service in the country was established in Dublin in 1955 at the Saint John of God Child Guidance Clinic in Rathgar. At that time and during the next 15 years, psychologists were primarily engaged in carrying out psychological assessments in child and adult services. Since the early 1970s, the nature of professional work in clinical psychology has expanded considerably. Psychologists now work with all age groups, are employed in many different settings and undertake a wide range of functions, including a variety of intervention procedures and consultancy work.

While psychologists in Ireland work in a wide variety of fields, the majority are employed in health services operated by statutory and non-statutory organisations. The results of our 1993 survey reported in Chapter 2 shows that psychologists are concentrated in three main specialties: child mental health services; adult mental health services; and services for people with intellectual and physical disabilities. In 1975, The Psychological Society of Ireland (PSI) published a Policy Statement *Psychology in the Service of Health* which set out the basis on which psychological services should be developed. The document includes sections on the functions of psychologists, the organisation and staffing of psychological services and on the qualification and training of psychologists for the health services. The establishment of formal University-based courses in clinical psychology was strongly advocated. At the time the document was written, no such formal courses were available here, but Health Boards had begun to sponsor psychologists to train on clinical psychology courses in the UK.

The number of clinical psychologists has grown from approximately 20 in the mid-sixties to over 300 today. Despite the growth of the number of psychologists employed in the health services, there is currently a serious shortfall of qualified clinical psychologists. A recent review of training need of Health Boards who contribute to the UCD clinical psychology training sponsorship scheme showed a high vacancy rate. Moreover, many health Boards Surveyed hoped to increase their number of clinical psychology posts over the next few years.

Following the current trend, clinical psychologists will be required to fill

posts in

- Child mental health and community care
- Adult mental health and
- Intellectual disability.

However, psychologists should probably also provide services in a number of specialist areas outlined as priority areas for service development in the current Irish national health policy document, *Shaping a Healthier Future* (Department of Health, 1994). These include the following:

- Children and adolescents who are violent and out of control
- Neuropsychological problems in children, adults and older adults
- Older adults
- Paediatric physical illness (diabetes, asthma etc.) and paediatric physical disability
- Adult physical illness (coronary care, chronic pain management)
- Drug abuse (including illegal drugs, alcohol and nicotine) treatment and prevention
- Prevention programmes (family violence, suicide, underage pregnancy etc.)
- Palliative care (for people with AIDS, terminal cancer etc.)
- Minority groups (such as the travellers)

There is a clear need to train sufficient psychologists to develop services in these domains. From a service management viewpoint, psychologists working in many of these areas are a good health-care investment because psychological interventions help patients to spend fewer days in hospital beds and in some instances prevent them from entering hospital or health centres in the first instance.

Clinical psychology training

The M Psych Sc clinical psychology training programme was established at UCD as in 1977. In 1978, an in-service training course, which led to the award of a

British Psychological Society Diploma in Clinical Psychology, was established by the Eastern Health Board in association with TCD. The in-service course was replaced by a three year MSc in clinical psychology in 1993. In 1997 the masters level programmes in clinical psychology at both UCD and TCD were replaced by three year practitioner doctorates in clinical psychology, the D Clin Psych at TCD and the D Psych Sc at UCD. This move to practitioner doctorates followed a similar development which had occurred in Britain and Northern Ireland a number of years earlier. It also brought clinical psychology in Ireland into line with North America where all licensed clinical psychologists hold either practitioner doctorates (PsyD) or PhDs in clinical psychology. Another important development was the setting up of the Psychological Society of Ireland's Diploma in Psychology which offered an avenue to in-service training through supervised on-the-job clinical practice coupled with independent study evaluated by PSI examinations, case studies and research projects. The PSI Diploma partly followed a model of training pioneered by the British Psychological Society. In the mid 1990s an arrangement was made where PSI Diploma candidates could complete their academic and research requirements through the University of Ulster. In addition to these training routes for clinical psychologists, a small number of Irish psychologists have been trained in the UK, the US and Canada.

The numbers of training places for clinical psychologists in Ireland is relatively small. Since 1997 the UCD course has accepted 9 new candidates every 2 out of 3 years. The TCD course accepts 6 new candidates every year. So currently, at any one time point, there are a total of only 36 clinical psychologists in training on the UCD and TCD courses and the output from these courses jointly is an average of 12 psychologists per year. The number of candidates enrolled in and graduating from the PSI diploma has been steadily increasing.

The reasons why so few clinical psychologists are being trained is because training standards are extremely high and the costs of resourcing high quality training programmes which meet these standards is considerable. Both the Psychological Society of Ireland and the British Psychological Society have established criteria for the accreditation of training programmes, and the stringency of these criteria make the expansion of courses prohibitively complex

and expensive. Each clinical psychologist over the course of a three year training programme must complete six placements of supervised clinical practice in at least four different specialties (child mental health, adult mental health, disability, and other specialties). These are typically of 4-6 months duration. Supervision must be offered by a psychologist who is at, or eligible for senior grade status. Each psychologist must also conduct a major research project and write this up as a thesis. In addition all candidates complete coursework on child mental health; adult mental health; disability services; practice in minor specialties; research design, methods and statistics; and professional issues which are examined by a combination of essays, case studies, research projects, and both written and oral examinations. During training, psychologists are either employed as trainees or funded through sponsorships. In the past, the Eastern Health Board and Saint John of God's services have funded psychologists to train at TCD. The remaining 7 Irish Health Boards have funded psychologists to train at UCD.

THE NEED FOR EMPIRICAL EVIDENCE ON CLINICAL PSYCHOLOGY

As clinical psychology has been developing in Ireland, many of us within the profession have been struck by the diversity of the roles which clinical psychologists adopted and by the stress entailed by training and practice within clinical psychology. It was a curiosity about these issues and a commitment to developing a solid empirical foundation from which to make statements about the development of the profession that the studies in the current volume evolved. The volume as a whole addresses a number of questions of central concern to the development of clinical psychology as a profession. First, it asks what are the profiles of clinical psychologists in terms of qualifications, employment patterns and professional practices. Second, it asks about the roles clinical psychologists currently occupy and how these differ from those that psychologists would like to adopt or anticipate they will adopt in future. Third, it asks specifically about the role of the clinical psychologist in child protection. Fourth, it asks how stressful

the training process and the early years of practice are. Finally, it asks about the levels of sexual, physical and verbal harassment to which clinical psychologists are exposed in their professional lives by clients. The remainder of this chapter offers a summary of the answers found to these questions by the rigorous research described in detail in Chapters 2 through 6 of the volume.

A NATIONAL SURVEY OF CLINICAL PSYCHOLOGISTS IN IRELAND

The results of a 1993 national survey of 111 clinical psychologists in Ireland conducted by Alan Carr are presented in Chapter 2. This study aimed to develop a profile of clinical psychologists in Ireland. In this study a third of the group had a two year masters degree in clinical psychology; a third had on-the-job training; and a third had a diploma, doctorate or one-year masters degree in clinical psychology. Respondents had a mean of 13 years clinical experience and an average of 3 previous jobs in clinical psychology. Half the sample were employed in voluntary organizations and just over a quarter were employed by health boards in the special hospitals or community care programmes. 31% worked in child and family specialty, 30% in mental handicap and 23% in adult mental health. 41% were senior grade, 23% were basic grade and 19% identified themselves as service directors or consultants. 87% worked full-time and adopted complex roles involving up to 11 different activities including treatment (27%), assessment (20%), staff training (8%), research (6%), service planning (5%) and preventative education (3%). The median case load was 51; the average waiting list was three months; and it contained 22 cases. Cognitive behavioural (55%) and family systems (29%) were the most common theoretical models. Two thirds of the research projects conducted were completed by 32 of the 111 psychologists surveyed. 61 of the 111 respondents conducted some private practice but only 6 were in full time private practice. Two thirds reported high levels of job satisfaction. All were involved in one or more of 11 continuing professional development activities to which employers contributed less than 50% of the costs.

The results of this survey underline clinical psychologists' flexibility in being able to fulfil complex roles in diverse organizational contexts. The group surveyed worked in many contexts, changed work contexts relatively frequently and indeed worked abroad before returning to import new expertise into Ireland. The survey paints a picture of clinical psychologists in Ireland as a small but highly trained group of professionals who share certain core clinical, research and organizational skills but who also are segmented into three definitive specialties.

An important question raised by this survey is how clinical psychologists as a highly trained yet numerically small group of professionals can be most usefully deployed within the health service. In the UK, two major reviews of clinical psychology services have concluded that the most efficient model for service delivery is through a *shared care* approach and the adoption of a *consultant role* by clinical psychologists (MAS, 1989; MPAG, 1990). Clinical psychology would become a consultant led service with a remit to meet population health needs across the board rather than being confined to the areas of mental health and disability. Such a psychology service would aim to promote and monitor healthier lifestyles through preventative programmes and ongoing evaluative research. There would be a greater emphasis on psychologists developing treatment programmes and training other professionals in their implementation. Psychologists would also offer direct psychological services to compliment medical strategies in a partnership with colleagues from medicine and other disciplines. This shared-care/consultant-role model for clinical psychology services fits particularly well with current national plans for the development of the health service (Department of Health, 1994).

CLINICAL PSYCHOLOGISTS' ROLES

In Chapter 3 Alan Doran and Alan Carr present the results of a survey of the roles of clinical psychologists employed by eight health boards in the Republic of

Ireland in 1994 and 1995. This study aimed to highlight differences between psychologists current roles, the roles they wished to adopt, and the roles they anticipated they would adopt. There were clear differences between the actual roles of respondents and their desired roles. Respondents wanted more responsibilities in the areas of service planning and organization; teaching and supervision; research and evaluation; and public relations. They wanted fewer face-to-face clinical responsibilities in the areas of child protection assessment and therapy; child psychiatric difficulties and child learning difficulties. They also wanted less routine administration. Differences between respondents' actual roles and the roles they realistically expected they would be required to fulfil in the future were similar to those between their actual and desired role responsibilities with a few notable exceptions. They expected there would be little change in their responsibilities for child protection assessment and therapy, despite their desire to reduce their responsibilities in these areas. A content analysis of responses to open-ended questions underlined respondents' view that the unique contribution of clinical psychology to the Health Boards may shift from the current emphasis on face-to-face clinical service delivery to the provision of a broader consultancy service in the future.

The wish and expectation that teaching and supervision; research and evaluation; organizational consultancy; and public relations will all become an increasingly significant part of the clinical psychologists role in the future underlines the growing confidence within the profession in Ireland that the broad role of the clinical psychologist set out in relevant UK reports (MAS, 1989; MPAG, 1990) will inevitably develop in Ireland. This may offer a way in which clinical psychologists as a highly trained yet numerically small group of professionals can be most usefully deployed within the health service. Factors that may facilitate the evolution of the role of the clinical psychologist identified in this study include participation in management, improved organization of the profession, increases in staffing; increases in training opportunities and an improved career structure.

CLINICAL PSYCHOLOGY

AND CHILD PROTECTION

The role of clinical psychologists in child protection is addressed by Elaine O'Brien, Sean Carey and Alan Carr in Chapter 4. In this 1998 survey of 140 clinical psychologists working in eight Health Boards and voluntary agencies in the Republic of Ireland, the most salient finding is that clinical psychologists have a role in child protection and abuse work and that this role is multifaceted and more complex than that documented in other international studies. Furthermore, not only were clinical psychologists from child mental health services involved in child protection work, but so too were psychologists working in adult mental health and services for people with physical and intellectual disabilities. Clinical psychologists' child protection work spanned a number of domains including validation, general assessment, risk assessment, treatment of victims and offenders, consultation with other disciplines, administration and report writing, prevention, research and providing staff support. 83% of respondents had received specialist post-qualification child protection in-service training and most psychologists found this helpful. 78% reported that their role in child protection was clear and unambiguous and that they carried out this role satisfactorily. All respondents followed procedural guidelines for child protection work. When clinical psychologists' actual and desired roles in child protection were compared, they wished their roles to change in two main ways. On the one hand, they wanted to become more involved in prevention work, research on child abuse and the treatment of offenders. On the other, they wanted to reduce their involvement in validation, assessment, consultation to other professionals, administration and report writing. They did not wish to change their input to the treatment of victims or providing staff support. When their actual and anticipated future roles in child protection were compared, they expected that their roles would change in two main ways which partially met with their wishes. They anticipated that their input to the treatment of offenders would increase and their input to assessment, validation, consultation, administration and staff support would decrease. They anticipated little change in their input to treatment of victims, prevention and research. Over 90% of clinical psychologists were dissatisfied with their role in the child protection area, although overall over 80%

of clinical psychologists were at least moderately satisfied with their jobs as a whole. While there were different patterns across specialties and grades, a number of extrinsic and intrinsic role related factors were identified as significant predictors of role satisfaction. Higher levels of specialist training in child protection and more time spent in child protection work were the most significant extrinsic job factors contributing to role satisfaction. The most significant intrinsic job factors contributing to role satisfaction identified were higher levels of input in the areas of prevention, research, treatment of offenders and staff support and lower levels of input in the areas of assessment, validation and consultation to other disciplines. While there were different patterns across specialties and grades, a number of factors were identified as significant predictors of general job satisfaction. These included the availability of social support, role satisfaction and psychological well-being.

Two important implications of these findings for policy, practice and training must be highlighted. First, it is clear that clinical psychologists have a responsibility to let their health care service managers and professional colleagues know about the complexity of the roles they adopt with respect to child protection. They must also let them be aware of their wish to renegotiate these roles in ways that would reduce role dissatisfaction in the child protection domain so as to minimize attrition and burnout. Second, there is a need to promote the importance of continuing professional development and training in the area of child protection since this is one of the important extrinsic job factors that promotes role satisfaction.

STRESS AMONG RECENTLY QUALIFIED PSYCHOLOGISTS AND PSYCHOLOGISTS IN CLINICAL TRAINING

Claire Donohoe, in Chapter 5 reports on a survey of stress among recently qualified psychologists and psychologists in clinical training. The survey was conducted in 1996 and involved 31 clinical psychologists in training and 21 recent graduates of clinical psychology training programmes at TCD and UCD. Twenty nine percent of clinical psychologists in training and 34% of recently

qualified psychologists showed clinically significant levels of stress responses as assessed by the GHQ-28 (Goldberg, 1978). Stress response levels increased significantly as the number of years post-qualification increased, but not over the course of training. Both pre- and post-qualification psychologists reported similar levels of stressors on the Revised Stress Survey, but psychologists in the first year of clinical training experienced more organisational stressors than those in second and third year. Trainees and recently qualified clinical psychologists reported differing patterns of occupational stressors as assessed by the Revised Stress Survey. Trainees listed the following 6 items in their top ten stressors: deadlines, not enough time for research, exams, changing placements, the amount of written work, and managing the conflicting roles of student and professional. For recently qualified psychologists the following 6 items were included in their top ten stressors: too much work, changing jobs, managing difficult clients, lack of resources at work, conflicts with other professionals and working in a hierarchical organization. The 4 items which were listed in the top ten stressors by both psychologists in training and recently qualified psychologists were: too many different things to do, fatigue, uncertainty about their own abilities and feeling inadequately skilled. A significant proportion of both groups reported that stress had an impact on their work, social life, personal relationships and view of self. Almost all respondents reported that their most frequently used and most effective coping strategy was talking to other trainees or psychologists. Occupational stressors identified in narrative accounts of clinical psychologists in training could be classified as those related to course structure and functioning, academic demands, placements, supervision, client-related difficulties, professional self-doubt, the management of personal issues in professional practice, and lack of control over the training process. Suggestions to alleviate training-related stress centred on reducing academic work, improving current support structures and the introduction of new ones. Occupational stressors identified in narrative accounts of recently qualified clinical psychologists could be classified as those related to the high number of organisational and professional demands, the high number of demands from complex suicidal and child abuse cases, and an isolated and unsupportive working context. Suggestions for alleviating stress during the post-qualification

years centred on introducing structures to help trainees make the transition to the basic grade role, improving support and supervision structures, and changing organisational structures to make the role of the basic grade psychologist less ambiguous and demanding. Results of this study were compared with those of similar UK studies. Both Irish trainees and qualified psychologists reported being exposed to greater levels of occupational stressors than UK trainees. Despite this, fewer Irish trainees showed clinically significant levels of stress responses, as assessed by the GHQ-28, compared with their UK counterparts. Qualified clinical psychologists on both sides of the Irish sea showed similar levels of stress responses.

Four implications of the results of this study for policy, practice and training deserve particular mention. First, within the profession as a whole there is a need for increased acknowledgement of the demanding and stressful nature of the role; the value of managing stress levels at a personal and organizational level; the importance of keeping work-role demands to realistically manageable proportions; and the importance of developing support and supervision structures to facilitated good practice in the area of stress management. Second, within training programmes there is a need to engender an ethos of self-care; to create participative structures that permit trainees to have greater control over the training process; and to create support structures that promote stress management during training which will also have carry-over effects and permit good stress management following graduation. Third, during the post-qualification years there is a need for support structures that permit young professionals to manage the transition from trainee to basic grade clinical psychologist status. Fourth, a wide variety of support structures and processes for clinical psychologists in training and newly qualified psychologists deserve exploration. These include individual and group based psychotherapy and personal growth work; mentoring; hierarchical supervision; peer supervision; routine appraisal, and stress management training.

HARASSMENT OF CLINICAL PSYCHOLOGISTS BY CLIENTS

In Chapter 6, Deirdre Dunne and Alan Carr report on a survey of harassment of clinical psychologists by clients. In this survey conducted in 1997 and 1998 it was found that over two thirds of 137 clinical psychologists working in Irish Health Boards and Voluntary Bodies had experienced at least one sexual, physical and verbal potentially negative interaction with a client. 26% considered that they had been sexually harassed by clients; 36% that they had been physically harassed and 64% that they had been verbally harassed. A significant minority had experienced extremely negative interactions with clients, 2% had been sexually assaulted, 18% physically assaulted, and 85% subjected to verbal abuse or suicide threats. The most harassing sexual interactions were requests for intimate physical contact, being brushed up against, touched or grabbed and being asked for a date. The most harassing physical interactions were being cornered by a client, having clients describe fantasies of physical violence involving the clinician, and being stalked. The most harassing verbal interactions were receiving suicide threats, having complaints made to senior clinicians and being phoned at home or at work without permission to do so. The frequency with which particular negative interactions occurred differed across specialties. In terms of negative sexual interactions, requests for hugs, being brushed up against, grabbed or touched in a grossly inappropriate way were more commonly reported by psychologists working with people with intellectual and physical disabilities compared with those working within the adult or child mental health specialties. With respect to negative physical interactions, reports of clients making intimidating gestures, throwing objects, denying access or exit from rooms, pushing, kicking and physically assaulting clinicians were more commonly made by psychologists working in the areas of intellectual and physical disability and adult mental health. With respect to negative verbal interactions, more psychologists working in the area of adult mental health reported inappropriate phone calls to the home or office and also threats of suicide compared to clinicians working in child mental health or disability services. For sexual, physical and verbal negative interactions, problem solving and reappraisal based coping strategies were more commonly used than strategies that aimed to regulate distressing emotional states or facilitate avoidance of the

threatening situation. Seeking support from colleagues, addressing the issues raised by the negative interaction with the client, and taking self-protective measures were the most commonly used problem-solving coping strategies. Reframing negative interactions as therapeutic issues rather than sexual, physical or verbal aggression was the most common reappraisal strategy. Problem-solving based coping strategies were perceived to be the most effective. Negative interactions with clients and harassment by clients were unrelated to clinical psychologists stress levels as assessed by the GHQ-28.

The results of this study have two important implications. First, information on recognising and managing negative interactions with clients effectively should be introduced into clinical psychology training courses. Second, institutions which employ psychologists need to develop appropriate guidelines and policies to help protect their employees from unwanted negative interactions with clients. In-service courses for managing difficult situations both inside and outside the therapy rooms are warranted as a routine part of continuing professional education and development.

CONCLUSIONS

Over the past 40 years clinical psychology has developed into an important profession containing 300 members with complex and diverse roles. Clinical psychologists are employed in three main areas: child mental health services; adult mental health services; and physical and intellectual disability services, but with increased numbers, clinical psychology could make significant contributions to other areas such as older adult care, paediatrics, coronary care, drug abuse, prevention programmes, and palliative care.

Clinical psychologists as a highly trained yet numerically small group of professionals may be most usefully deployed within the health service through adopting a *shared care* approach and taking a *consultant role*.

Most clinical psychologists in Ireland are trained through UCD or TCD courses or through the PSI Diploma. The numbers of psychologists being trained does not meet the demand. Resourcing existing training programmes and

initiating new ones to increase the numbers of psychologists within the profession is an important priority for future development.

Because of the stressful nature of clinical psychologists' roles during and following training, the profession needs to underline the value of managing stress levels in planned ways at a personal and organizational level; the importance of keeping work and training role demands to realistically manageable proportions; and the importance of developing support and supervision structures to facilitated stress management during training and in professional practice.

Because of the prevalence of negative sexual, physical and verbal interactions with clients, there is a need for training programmes, policies and practices to help psychologists manage harassment by clients in a professional manner.

There is also a need to promote the importance of continuing professional development and training in the area of child protection since this is one of the important extrinsic job factors that promotes role satisfaction and prevents professional burnout.

REFERENCES

- Brady, T. & McLoone, J. (1992). Ireland. In V.S.Sexton & J.D.Hogan (Eds.), *International Psychology. Views from around the World.* (2nd ed). Lincoln, NE:University of Nebraska Press.
- Brady, T. (1990). Clinical Psychology in Ireland. *Clinical Psychology Forum*, November, 1990.
- Department of Health (1994). *Shaping a Healthier Future. A strategy for effective helthcare in the 1990s.* Dublin. Stationary Office.
- Goldberg, D. (1978). *General Health Questionnaire.* Windsor, UK: NFER-NELSON.
- MAS (1989). *Review of Clinical Psychology Services.* London. Mowbray.
- MPAG (1990). *Clinical Psychology Project: Full Report.* London. Department of Health
- Psychological Society of Ireland (1975). *Psychologists in the Service of Health.*

Dublin: The Psychological Society of Ireland.
