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CHAPTER 2

A National Survey of Clinical Psychologists In Ireland

Alan Carr

SUMMARY

The results of a 1993 survey of 111 clinical psychologists practising in Ireland are presented in this paper. 55% of respondents were female and 45 percent were male with a mean age of 39 years and 7 months. 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 (366/527) 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 are discussed in the light of similar surveys conducted in the US and the UK. Implications for the profession are also considered.

INTRODUCTION

Surveys of clinical psychologists have been conducted in the US and the UK to document the development of the profession in these countries. In recent years the most notable of these have been carried out by John Norcross and his colleagues (Norcross, Dryden & Brust, 1992; Norcross, Brust & Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b). To date, in Ireland, similar surveys have not been conducted either to document the development of the profession or to compare the development of clinical psychology in Ireland with its development in other countries. The present survey aimed to fill this particular gap in our knowledge. More specifically, this survey aimed to draw an accurate profile of the practice of clinical psychology in the Republic of Ireland in the early 1990's with particular reference to seven areas:

1. Demographic characteristics, qualifications and professional affiliations
2. Employment patterns including career course, work setting, employers, specialty and grading
3. Workload, professional activities, approach to practice and theoretical orientation
4. Research and publications
5. Private practice
6. Job satisfaction
7. Continuing professional development

A subsidiary aim of the survey was to compare the status of Irish clinical psychologists with that of their US and UK counterparts.

METHOD

Participants.

The population under investigation included all clinical psychologists in the Republic of Ireland. Unfortunately, identifying this total population was not possible since, in the Republic of Ireland, registration for clinical practice is not mandatory and so no national register exists. The Psychological Society of Ireland's (PsSI) Directory of Psychologists (1993) is the closest available approximation to a comprehensive national register and so this source was used to identify participants for the survey. The PsSI Directory lists the name and address of all PsSI members along with information about their qualifications and appointments. PsSI members were included in the survey if they were either employed or qualified as clinical psychologists. There were 234 such cases. Those involved in work germane to clinical psychology including rehabilitation and mental handicap; psychotherapy; individual, couples and family counselling and therapy; behavioural analysis; neuropsychology; addiction services; health psychology and clinical forensic psychology were also included. There were 90 such cases. Members of PsSI were excluded if they identified themselves as organizational psychologists; experimental psychologists; educational psychologists without clinical responsibilities; educational and vocational guidance counsellors and PsSI members practising outside the Republic of Ireland (although inadvertently a number of such cases were surveyed and later discarded). A total of 324 PsSI members were identified using these inclusion and exclusion criteria.

Instruments

A questionnaire was compiled with items covering the seven areas listed above in the introduction. The items were based on consultation with a group of clinical psychologists in practice throughout the country in a range of clinical contexts. Items were also selected so that comparisons could be made between Irish data and the results of similar surveys conducted in the US and UK by John Norcross and his colleagues (Norcross, Dryden & Brust, 1992; Norcross, Brust and Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b). The six page questionnaire contained 55 items. A pilot study showed that the questionnaire required about 20 minutes for completion. A copy of the questionnaire is contained in an appendix to this paper.

Procedure

Questionnaires were mailed to participants with a covering letter and SAE in the Irish Psychologist in the summer of 1993. The newsletter contained a notice describing the aims of the survey and asking members to complete and return questionnaires promptly. The following instructions were given in the letter:

> Dear Colleague. I am writing to ask for your help. If you are currently involved in the practice, research or teaching of clinical psychology or a closely related field, please complete and return the enclosed questionnaire. A stamped addressed envelope is enclosed for your convenience. May I ask you to take particular care not to put your name or any identifying information on the questionnaire and also to be as frank as possible in answering the questions. Please return the questionnaire to me here at UCD as soon as possible. Many thanks for your help.

RESULTS

Response Rate.

Of 324 questionnaires, 142 were returned. This represents an overall response rate of 44%. Requests to return questionnaires were not sent to non-responders since this would have violated the guarantee of anonymity given to all participants.

111 respondents were qualified clinical psychologists or were working as clinical psychologists. The data presented below are based on the responses of this group.

Of the remaining 31 cases, 20 respondents clearly identified themselves as counselling psychologists. They had a primary degree in psychology and a graduate degree or professional diploma in counselling. These are excluded from the analyses below because counselling psychology is currently evolving as a separate professional discipline within psychology. Nine of the remaining respondents were academic psychologists with clinical research interests; psychologists involved in administrative or research work relevant to clinical psychology or psychologists practising outside the Republic of Ireland. Two questionnaires were excluded because they were largely incomplete.

Data management

Data from the questionnaires were analysed using SPSS (Norusis, 1990). On no item were there more than 10% missing data. Three main sets of analyses were conducted. First, descriptive statistics for the group of 111 clinical psychologists were computed. These included percentages for categorical variables and means and standard deviations for interval scale variables. Throughout this paper percentages have been rounded up to the nearest whole number to simplify presentation.

In the second set of analyses three groups of psychologists, each at different ***grade levels,*** were compared on all remaining variables. The first group

contained 26 basic grade psychologists. The second group contained 45 senior grade psychologists and there were 20 in the third group who were service directors or at consultant grade. It is worth mentioning that those assigned to the third group had job titles that included the term *service director* or *consultant*, although some of these may actually have been on a senior grade salary. Respondents who could not be classified within the threefold scheme worked in universities, private practice or other agencies. These cases were omitted from the analyses by grade since they could not be classified into homogenous groups of sufficient size to permit reliable statistical analyses to be conducted.

In the third set of analyses, three groups of psychologists, each in different ***specialties*** , were compared on all remaining variables.

There were 33 in services for the mentally handicapped, 34 in child and family services and 26 in adult mental health services. The remaining participants, who were omitted from the third set of analyses, worked in other specialties such as neuropsychology, health psychology or behaviour analysis. These cases were omitted from the analyses by specialty since they could not be classified into homogenous groups of sufficient size to permit reliable statistical analyses to be conducted.

For the analyses by grade and specialty one-way ANOVAs and Student Newman-Keuls tests were used for all intergroup comparisons on interval scale variables. On categorical variables Chi Square tests were conducted with Yates correction for continuity where cell frequencies were less than 5. Only intergroup differences that were of professional interest and statistically significant at $p<.05$ are reported.

In the next seven sections descriptive statistics for the sample as a whole are presented first. Thereafter, statistically significant results of professional interest are presented from the analyses based on grade and specialty.

Demographic characteristics, qualifications and affiliations.

Demographic characteristics are given in Table 2.1. Ages of the group ranged from 26 to 64 years with a mean age of 39 years and 7 months. 55% were female and 45% were male. Almost three quarters were married (73%) and 22% were single.

With respect to qualifications, the sample was split three ways. About a third had a two year professional masters degree in clinical psychology (34%). About a third had on-the-job training (36%). The reminder had either a one year masters degree in clinical psychology (18%), a diploma in clinical psychology (6%) or a doctorate in clinical psychology (5%).

Diplomas in psychotherapy (5%), diplomas in counselling (5%), masters degrees in counselling (3%) and masters degrees in psychotherapy (1%) were rare among the group surveyed.

Table 2.1. Demographic characteristics

Variable	Category	%
Age	Mean = 39y 7 m Range = 26y -64y	
Gender	Female	55
	Male	45
Marital status	Married	73
	Single	22
	Other	5
Clinical psychology qualifications	On the job training	36
	Accredited masters in clinical psychology	34
	Masters in clinical (1y)	18
	Diploma in Clinical Psychology	6
	Doctorate in Clinical Psychology	5
Psychotherapy and counselling qualifications	Diploma in psychotherapy	5
	Diploma in counselling	5
	Masters in counselling	3
	Masters in psychotherapy	1
PsSI	Registered psychologist	72
	Graduate member	41
	AFPsSI	52
	FPsSI	5
BPsS	Chartered psychologist	20
	Graduate member	21
	AFBPsS	19
	FBPsS	0

Union membership	IMPACT	48
	MSF	18
	SIPTU	2
	None	32
Insurance	BPsS Scheme	20
	PPS Scheme	15
	Other	6
	None	59
Main specialty	Child and family	31
	Learning difficulties	30
	Adult Mental Health	23
	Psychotherapy	5
	Physical disability	3
	Family therapy	2
	Older adult mental health	2
	Health psychology	1
	Behavioural analysis	1
	Other	1

Table 2.1. Demographic characteristics

Variable	Category	%
Grade	Senior	41
	Basic	23
	Consultant/Director	19
	Consultant i n private practice	5
	Principal	2
	Lecturer	2
	Senior Lecturer	2
	Other	6
Employer	Voluntary organization	50
	HB special Hospital	16
	HB Community Care	13
	Private practice	8
	University	5
	Private hospital	4
	Private Institute	1
	Other	3
Work setting	Health centre/Outpatients	25
	Residential care centre	11
	Private institute	10
	Public psychiatric hospital	9
	Private practice	6
	University	5
	Children's hospital	4
	Private psychiatric hospital	3
	General hospital	3
	Other	24

Note: N=111.

About three quarters of the sample (72%) were Registered Psychologists with the Psychological Society of Ireland (PsSI). Only a fifth (20%) were Chartered Psychologists with the British Psychological Society (BPsS). Just over half (52%) were Associate Fellows of PsSI and about a fifth (21%) were Associate Fellows of the BPS. 41% were graduate member of PsSI and 21% were graduate members of the BPS. Only 5% were Fellows of PsSI and none were Fellows of the BPS.

Over half of the sample (59%) had no professional indemnity insurance. Those that had such insurance obtained their policies through either the Professional Psychologists Society (15%) or through the BPsS scheme (20%) or some other body (6%).

Almost a third of psychologists (32%) were not affiliated to any union.

About half (48%) were in IMPACT (the Irish Municipal Public and Civil Trade Union) and about a fifth (18%) were in MSF (the Manufacturing, Science and Financial trade union) with only 2% in SIPTU (the Services, Industrial and Professional Trade Union).

Employment patterns: career course, work setting, employers, specialty and grading

Within the sample the number of years of clinical experience ranged from 1-30 with a mean of 13. The mean number of jobs held was 3 with a range from 1-9. 69 (62%) psychologists had at some stage worked with the health boards and the mean number of years for which they worked was 8 with a range from 1 to 26. 39 (35%) of the psychologists surveyed had worked abroad for an average period of 3 years with a range from between 1 and 13 years.

Table 2.2. Employers of clinical psychologists in each specialty

Specialty		Empl oyer			
		Voluntary organization	Health board community care	Health board special hospital	Other
Child mental health	%	47%	24%	9%	21%
	f	16	8	3	7
Adult mental health	%	19%	12%	50%	19%
	f	5	3	13	5
Intellectual Disability	%	94%	3%	0%	3%
	f	31	1	0	1

Note: Chi square = 48.49, p<.0001, df = 6, N=93.

Table 2.3. Factors associated with the grading of clinical psychologists

Variable		Gra de			χ^2 or F
		Basic Grade (N=26)	**Senior Grade** (N=45)	**Director Consultant** (N=20)	
Male	%	27%^{b}	44%^{b}	75%^{a}	10.62*
	f	7	20	15	
AFPsSI or FPsSI	%	15%^{b}	62%^{a}	75%^{a}	22.94**
	f	4	28	15	
Reg Psychol PSsI	%	35%^{b}	76%^{a}	90%^{a}	19.43**
	f	9	34	18	
PhD	%	0%^{b}	7%^{b}	30%^{a}	12.40*
	f	0	3	6	
Union Member	%	84%^{a}	73%^{a}	47%^{b}	8.81*
	f	22	32	9	
Years of experience	M	7.11^c	13.69^b	16.85^a	17.76**
	SD	6.08	5.27	6.54	
Number of research projects	M	2.24^b	3.06^b	6.36^a	7.45**
	SD	1.53	2.38	6.92	
Number of presentations	M	1.33^b	3.86^b	14.55^a	11.02**
	SD	1.92	4.41	19.68	
Number of publications	M	0.70^a	3.30^a	9.55^b	5.86*
	SD	1.33	8.78	12.29	
Mean % time spent in consultation	M	3.00^a	4.77^a	11.68^b	8.43**
	SD	4.00	5.78	11.93	

Note. For categorical variables, frequencies are in parentheses and an overall chi square value with df = 2 and N = 91 is given in the right hand column. For interval scale variables, values in parentheses are standard deviations and in the right hand column an F value with df = 2, 88 is given. For overall chi squares and F values, * = p<.01 and ** = p<.001. In each row, values with different superscripts differ from each other at p<.05, with a>b>c.

A quarter of the sample worked in outpatient clinics or health centres with the rest being distributed across a range of work settings including residential care (11%), private institutes (11%), public psychiatric hospitals (9%), private practice (6%), universities or colleges (5%), children's hospitals (4%), and private psychiatric hospitals (3%).

Half of the sample were employed in voluntary organizations. Just over a quarter (29%) were employed by the health boards in special hospital or

community care programmes. The remainder were employed in private practice (8%), a university or college (5%), a private hospital (4%) or a private institute (1%). The bulk of the sample worked in three specialties: Child & family psychology (31%), mental handicap (30%) and adult mental health (23%). The remaining 15% of the sample were in numerically smaller specialties. These included psychotherapy (5%), physical disability (3%), family therapy (2%), the elderly (2%), health psychology (1%), and behavioural analysis (1%).

From Table 2.2 it may be seen that there was a statistically significant relationship between clinical psychologists' specialty and the context within which they were employed. Mental handicap psychologists were employed largely in voluntary oragnizations. About half of child and family psychologists were employed with voluntary organizations and about a quarter with the health boards community care programmes. For psychologists working in the adult mental health specialty, the major employer was the health boards special hospital programme, with 50% of them working in it.

The majority of those surveyed were working at one of three grade levels: senior grade (41%), basic grade (23%), or consultant/director grade (18%). The remaining 18% were either consultants in private practice (5%); at a principal grade in a voluntary organization (2%); at lecturer (2%) or senior lecturer (2%) grade in a university or at some other grade designation (7%).

From Table 2.3 it can be seen that directors and basic grades have clearly different profiles. The Director or Consultant grade is associated with the following characteristics:

- Being Male
- Being an Associate Fellow or Fellow of the PsSI
- Being Registered with the PsSI
- Having a PhD
- Not being a union member
- Having about 17 years of experience
- Having a research track record
- Being involved in consultancy

The basic grade, on the other hand is typified by the following attributes:

- Being female
- Not being an Associate Fellow or Fellow of the PsSI
- Not being Registered with the PsSI
- Not having a PhD
- Being a union member
- Having about 7 years of experience
- Not having a research track record
- Having minimal involvement in consultancy

Workload, professional activities, approach to practice and theoretical orientation

More than four fifths (87%) of the sample were employed full time and for the sample as a whole the average working week was 37 hours with a range from 5-60 hours. The median case load was 51 with a range from 0-2400. The median rather than the mean offers a better reflection of the central tendency of this distribution because it was positively skewed by two extreme cases where caseloads of 1,500 and 2,400 were reported. These extreme values inflated the mean to 111. The average number of cases on a waiting list was 22 with a range from 0-240. The average duration of a waiting list was 3 months with a range from 0-24 months.

Psychologists were involved in 11 different professional activities. When activities were rank-ordered according to the mean percentage of time devoted to each the top three were direct treatment (27%), assessment and diagnosis, (20%) and routine administration (11%). Together treatment, diagnosis and administration for an average psychologist within the sample were taking up about three days a week. The next three activities to which psychologists devoted a substantial amount of time was indirect treatment (10%), staff training (8%) and research (6%). For an average psychologist within the sample a little over a

day a week was devoted to these three activities. Service planning (5%), consultation (5%), management (4%), public education (3%) and receiving supervision (1%) together on average were allocated just under a day a week.

Table 2.4. Mean percentage of assessment time spent on different procedures in each specialty

		Specialty			
		Child Mental Health (N=34)	**Adult Mental Health** (N=26)	**Intellectual Disability** (N=33)	**F**
Behavioural observation	M	4.76[b]	8.08[b]	17.81[a]	6.13*
	SD	8.58	19.91	17.00	
Intellectual testing	M	17.67[b]	7.52[c]	36.13[a]	17.78**
	SD	17.33	7.81	24.1	
Family Interview	M	18.76[a]	3.16[b]	12.16[a]	7.17**
	SD	21.94	5.33	12.50	
Neuro-psychological testing	M	1.90[b]	11.08[a]	1.55[b]	10.67**
	SD	3.47	15.34	3.40	
Individual interview	M	37.41[b]	54.00[a]	15.48[c]	13.75**
	SD	27.26	33.51	22.33	

Note. For each row, in the right hand column an F value with df = 2, 90 is given. * = p<.01, ** = p<.001. In each row means with different superscripts differ from each other at p<.05, with a>b>c.

Table 2.5. Theoretical models used by clinical psychologists in each specialty

		Specialty			x^2
		Child Mental Health (N=34)	**Adult Mental Health** (N=26)	**Intellectual Disability** (N=33)	
Cognitive behavioural	%	38%[b]	69%[a]	73%[a]	9.76*
	f	13	18	24	
Family systems	%	50%[a]	12%[b]	12%[b]	16.38**
	f	17	3	4	

Note. For each row, in the right hand column a chi square value with df = 2 and N = 93 is given. * = p<.01, ** = p<.001. In each row, means with different superscripts differ from each other at p<.05, with a>b.

When assessment procedures were rank-ordered according to the mean percentage of time the sample devoted to them, the individual clinical interview (35%) was the most common procedure with intellectual testing (20%), family interviewing (11%), behavioural observation and analysis (10%), neuropsychological testing (5%) and personality testing (5%) being less widely used. For all procedures, the range for the sample varied between 1% and 100% of psychologists' assessment time.

From Table 2.4 it can be seen that in the mental handicap specialty behavioural observation and intellectual testing were more commonly used than in the other specialties. The family interview was more widely used in the child and family and mental handicap specialties than in the adult mental health specialty. Neuropsychological testing was almost exclusively associated with the adult mental health specialty. The individual interview was used more commonly by psychologists in adult mental health than in the other two specialties and this procedure was used least by those in the mental handicap specialty.

When treatment formats were rank-ordered according to the mean percentage of time the sample devoted to them, individual therapy (50%) was the most widely used, with family therapy (11%), couples therapy (7%) and group therapy (6%) being used less commonly. However for all four treatment formats

the range for the sample was between 1 and 100% of treatment time devoted

Cognitive behavioural (55%) and family systems (29%) approaches were the two most commonly used non-eclectic theoretical frameworks. Humanistic/existential (13%) and psychodynamic (12%) approaches together were used by a quarter of the sample. 33% of the sample indicated that they used an eclectic approach and 42% of the sample used more than one model. From Table 2.5 it can be seen that a cognitive behavioural model was widely used by psychologists working in the mental handicap and adult mental health specialties. A family systems orientation was used more commonly by psychologists working in the child and family specialty when compared with the other two specialisms.

Research, presentations and publications

The median number of research projects carried out was 3. The median number of conference presentations was 2 and the median number of academic articles was 1. Median values are given because, for all three variables, the distribution was extremely positively skewed, and so means would give an inflated impression of the central tendencies within these distributions.

Most of the research projects were done by a few industrious psychologists. In all 527 projects were carried out. 2/3 of the projects (366/527) were completed by 32 psychologists (29% of respondents). Most of the conference presentations were made by a few highly prolific individuals. In all 632 presentations were made. 69% (434/632) or just over 2/3 were made by 20 psychologists (or 18% of respondents). Most of the articles were produced by a few highly prolific psychologists. In all 471 articles were written. 2/3 of the articles (308/471) were written by 13 (12%) of the 111 psychologists surveyed. 43 (39%) wrote none. 19 books were written by 10 (9%) of the psychologists surveyed and one prolific writer wrote 6 of these.

Only a minority of clinical psychologists were uninvolved in research and

publication. 14% of the sample had conducted no research projects. 27% had made no presentations and 39% had no publications.

Private practice

61 of 111 respondents (55%) were in private practice and all percentages in this section are based on N=61. Almost three quarters of this group (71%) were only in occasional private practice. 10% were full time and 14% were part time. 42% used consulting rooms, a quarter worked from home and about a quarter (26%) used the office at their main place of employment for private consultations. 7% worked at a private institute. For most psychologists, private practice was a solitary activity. About two thirds (69%) practiced alone. 20% practiced with other professionals and only 11% with other psychologists. On average 59% of the group's time was devoted to therapy and 31% to assessment. Hourly fees ranged from IR£20 to IR£60 with almost two thirds of the group (64%) using a sliding fee scale. IR£20-IR£30 was the fee range used by 43% of the group. The fees of 44% of the group fell in the IR£30-IR£40 bracket. For 11% of the group a fee of IR£40-IR£50 was used. Only 2% of the group charged between IR£50 and IR£60.

Table 2.6. Factors contributing to clinical psychologists' job satisfaction

Factor	%
Psychological intervention	67%
Variety of Tasks that make up job	49%
Teaching & Training	37%
Multidisciplinary team work	26%
Psychological Assessment	21%
Service Planning	16%
Indirect Assessment & Treatment via relatives & staff	17%
Research	14%
Relationships with other Psychologists	11%
Consultation	11%
Pay	7%
Management of Junior Staff	5%
Receiving Supervision	4%
Relationships with Social Workers	4%
Office facilities	4%
Relationships with psychiatrists	2%
Routine Administration	2%
Relationships with GPs	2%
Administrative resources	1%
Relationships with Management	1%
Relationships with Physicians & Surgeons	1%
Relationships with Nurses	0%
Work Load	0%

Note: N=111.

Job satisfaction.

Two thirds of the sample were very satisfied (22%) or quite satisfied (43%) with their job. 9% were slightly satisfied. The remainder were slightly dissatisfied (12%), quite dissatisfied (10%) or very dissatisfied (5%). Over half (56%) said that if they could choose their career again they would choose clinical psychology. The remainder said that if they could choose their career again they would choose another field of psychology (8%), law (6%), business (6%), medicine (5%) or some other field (19%).

From a list of 24 factors, respondents were asked to indicate the top three contributing to job satisfaction and job dissatisfaction. From Table 2.6 it may be seen that for job satisfaction, the top 5 factors identified by the sample were direct psychological treatment , the variety of tasks that make up the job, teaching and training, multidisciplinary team work and psychological assessment. For job

dissatisfaction, as can be seen from Table 2.7 the top five factors were work load, pay , routine administration, lack of administrative resources, relationship with management.

Table 2.7. Factors contributing to clinical psychologists' job dissatisfaction

Factor	%
Work Load	50%
Pay	37%
Routine Administration	33%
Lack of administrative resources	27%
Relationships with Management	26%
Relationships with psychiatrists	15%
Office facilities	14%
Service Planning	13%
Teaching & Training	6%
Direct Psychological Treatment	6%
Research	5%
Receiving Supervision	5%
Variety of Tasks that make up job	5%
Relationship with Physicians & Surgeons	5%
Multidisciplinary team work	5%
Management of Junior Staff	4%
Psychological Assessment	3%
Indirect Assessment & Treatment via relatives & staff	3%
Relationships with Social Workers	2%
Relationship with Nurses	2%
Relationships with other Psychologists	2%
Consultation	1%
Relationships with GPs	0%

Note: N=111.

Continuing professional development

The psychologists surveyed all engaged in some continuing professional development (CPD) activities. In analysing the data, these CPD activities have been rank ordered in terms of the percentage of psychologists engaging in each activity. From Table 2.8 it is clear that the top three CPD activities in which the majority of psychologists engaged were reading professional literature, conference attendance , and attending 1-2 day training workshops. Staff development workshops and journal clubs or case presentations (both team based

in-house CPD activities) were engaged in by about two fifths of those surveyed. Just over a quarter of respondents were engaged in personal psychotherapy as a CPD activity. A tenth or less were completing various part-time courses and extramural psychotherapy.

Table 2.8. Clinical Psychologists' participation in continuing professional development

Activity	%
Reading Professional Literature	91%
Conference Attendance	85%
1-2 day Skills Training Workshop	66%
Staff Development Workshop	42%
Journal Club or Case Presentations	40%
Personal Psychotherapy	27%
Part-time Certificate Course	10%
Extramural Psychotherapy Supervision	9%
Part-time Degree Course	9%
Part-time Diploma Course	5%
Distance Learning Programme	3%

Note: N=111.

When psychologists were asked what activities they would find most valuable in fostering their continuing professional development, as can be seen from Table 2.9, the majority put 1-2 day skills training workshops at the top of their list. Reading professional literature and attending staff development workshops were identified as desired CPD activities by about two fifths of the surveyed group. About a third valued conference attendance and personal psychotherapy as desired CPD activities. Extramural psychotherapy supervision on the one hand and in-house journal clubs or case presentations on the other were the next most prominently identified CPD needs. About a quarter of clinical psychologists wanted to engage in these CPD activities. Formal courses were the least commonly desired CPD activities.

Table 2.9. Continuing professional development activities that clinical psychologists would find most useful

Activity	%
Reading Professional Literature	43%
Staff Development Workshop	39%
Conference Attendance	33%
Personal Psychotherapy	32%
Extramural Psychotherapy Supervision	26%
Journal Club or Case Presentations	5%
Part-time Degree Course	16%
Distance Learning Programme	10%
Part-time Diploma Course	9%
Part-time Certificate Course	8%

Note: N=111.

The majority of clinical psychologists surveyed thought that personal growth work was ***essential*** in the initial training (54%) of clinical psychologists and also in their ongoing continuing professional development (51%). Over a third thought that it was desirable for personal growth work to be part of initial training (35%) and ongoing CPD (40%). Only about a tenth viewed personal growth work as an optional part of training (11%) and CPD (9%). From Table 2.10 it can be seen that significantly more psychologists at director or consultant grade viewed personal growth work as essential for initial training when compared with senior or basic grade psychologists. There was also a trend ($P<.07$) for directors to view personal growth work as essential for CPD in comparison with those from other grades.

Just over half of those surveyed (54%) believed that PSI should recommend certain levels of CPD activity. About a third (32%) believed that PSI should require certain levels of CPD activity in order for psychologists to be issued with practising certificates.

On average each clinical psychologist allocated 12 days of their own time to CPD each year (with a range of 0-52) while their employers only allocated 8 days to each psychologist per annum (with a range from 0-56). On average each clinical psychologist allocated IR£497 of their own funds to CPD (with a range for (IR£0-IR£2,500).

Table 2.10. Clinical psychologists who believe that personal growth work is *essential* for their initial training and continuing professional development

Variable		Gra de			χ^2
		Basic Grade (N=26)	**Senior Grade** (N=45)	**Director Consultant** (N=20)	
Personal growth work essential in initial training	%	42%^{b}	56%^{b}	80%^{a}	6.65*
	f	11	25	16	
Personal growth work essential in continuing professional development	%	54%^{b}	44%^{b}	75%^{a}	5.20†
	f	14	20	15	

Note. For each row in the right hand column a chi square value with df = 2 and N = 93 is given. * = p<.05, † = p=.07. In each row, means with different superscripts differ from each other at p<.05, with a>b.

For employers the amount allocated to each clinical psychologist's CPD was IR£375 per year. The range was IR£0-IR£4,000. These same data may be expressed in aggregate form. Altogether 77 psychologists devoted 990 days of personal time to CPD while the employers of 72 psychologists allocated only 742. In all 68 clinical psychologists allocated IR£40,765 to CPD while the employers of 57 psychologists allocated only IR£31,915. For almost half of the group surveyed (49%), employers allocated no finance for CPD and in about a third (35%) of cases employers allocated no time for CPD. Only about a third of psychologists devoted no personal finance (39%) or personal time (31%) to CPD.

DISCUSSION

Before addressing a number of substantive issues raised by the survey, the methodological issue of sample representativness deserves discussion. The near equal male/female ratio of respondents and the fact that 68% of the group to whom questionnaires were sent were female suggests that females may have been under-represented in the sample. The omission of non-PsSI member from the sample also compromised its representativness. The sample was therefore biased in favour of male PsSI clinicians. While differences and similarities between PsSI members and non-members are unknown, the data suggest that there is an association between gender and professional seniority. The profile of clinical psychology reflected in the results of the survey may be coloured by the over-representation of senior clinicians. With this in mind, let us turn to a discussion of a number of substantive issues raised by the overall pattern of results and to a comparison of these and the results of similar US and UK surveys. Unless otherwise indicated, all comparisons with US and UK data are based on John Norcross' recent studies (Norcross, Dryden & Brust, 1992; Norcross, Brust and Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b). To avoid unnecessary repetition, further citations of Norcross' surveys will not be made when making comparisons between US, UK and Irish data.

Demographically there marked similarities between Irish and UK clinical psychologists and substantial differences between both of these groups and their US counterparts. The gender ratio of respondents to this survey was identical to the gender ratio found in the UK but differed substantially from that reported in the US where the male/female ratio among clinical psychologists was 3:1. The mean age of clinical psychologists in this study was similar to that found in the UK but was eight years lower than the mean for US clinical psychologists.

The Irish clinical psychologists in the present survey were considerably less well qualified than their British or North American counterparts. While in Ireland only a third had masters and 5% had doctorates in clinical psychology, in the UK half had masters degrees and a quarter had doctorates. It the US almost

all clinical psychologists had doctorates. While just under three quarters of Irish psychologists had PSI Registered status, over 90% of British psychologists had BPS Chartered status.

With a mean of 13 years post-qualification experience, Irish psychologists fell between their UK and US counterparts who had 11 and 17 years post-qualification experience respectively. While outpatient clinics and health centres were the most commonly reported work settings for Irish psychologists, in the UK, psychiatric hospitals (23%) or general hospitals (22%) were the most common work sites. In the US, private practice was the most common working environment with over a third (35%) of clinical psychologists working in such a setting.

The present survey underlines 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 results of US and UK surveys show that the complex professional role adopted by clinical psychologists in Ireland is very similar to that of British and North American clinical psychologists.

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. However, the working structure for psychologists in Ireland appears to have evolved so as to maximize professional isolation. Specialists are attached to organizations that provide a service in their specialty. Specialists are not members of unitary psychology departments as in the UK (MAS, 1989; MPAG, 1990). In a profession as small as clinical psychology the current structures may be one factor compromising the impact of the profession in Ireland. The profession as a whole (in conjunction with other psychologists who provide health related services) needs to consider if the professional isolation that is currently the norm should be challenged through advocating and promoting the development of more cohesive organizational structures within which to practice.

The development of unified psychology departments of which specialists from all fields are members is one organizational structure that would greatly reduce professional isolation. To be consistent with current plans for the development of mental health services generally, ideally such departments would be community based and each department would serve a specific geographic sector (Department of Health, 1992, 1994).

In the US, the UK and Ireland clinical interviewing is the most commonly used assessment procedure and eclectic and integrative models of treatment were adopted by between a quarter and a third of all surveyed in all three countries. However, there are clear differences between the amount of time Irish, US and UK psychologists devote to specific assessment procedures and their allegiance to particular treatment models. US psychologists devote a third of their assessment time to objective and projective personality testing while Irish (5%) and British (3%) psychologists rarely use such procedures. Of the theoretically pure models, cognitive and behavioural theoretical orientations were by far the most common in Ireland (55%), the UK (49%) and the US (29%). While family-systems models were second in popularity in Ireland, psychodynamic models filled this slot in the US and the UK.

The pattern of research productivity found in this survey of Irish psychologists is remarkably similar to that found in US and UK surveys. In both countries a small proportion of the samples surveyed produced the majority of the publications and between a quarter and a third produced none. The median number of academic publications was highest for the US (6), next highest for the UK (2) and lowest for Ireland (1).

Irish psychologists fell between their UK and US counterparts in terms of their overall career satisfaction. While 67% of Irish psychologists said that they were quite satisfied or very satisfied with their career, 56% of UK and 89% of US psychologists expressed these levels of career satisfaction. However, comparable numbers of Irish (56%), British (50%) and North American (58%) clinical psychologists would choose clinical psychology if they could make their career choice again.

Clinical psychologists in Ireland take CPD seriously. Without guidance from PsSI or support from their employers, most psychologists engage in CPD. There is a clear need to establish a system for informing clinical psychologists and their employers about CPD opportunities and standards and facilitating its occurrence. In the US, the UK and Canada, professional bodies have drawn up clear criteria for the accreditation and recommendation of CPD courses and clear guidelines exist to help both psychologists and their employers to make decisions about the allocation of time and resources to CPD (BPsS, 1990; CPA, 1989, 1990; Hellkanp, Imm & Moll, 1989; VandeCreek & Brace, 1991). In Australia the process is less well developed (APS, 1993).

Personal growth work, personal psychotherapy and psychotherapy supervision were recognized by the sample surveyed as significant aspects of CPD. This is consistent with Rothery's (1992) finding that 50% of clinical psychology trainees believed that personal growth work was an essential part of their initial training. Some good examples of how personal growth work may be incorporated into initial training have recently been published (e.g., Eayrs, Appleton & Lewis, 1992). The fact that there is a lack of unanimity among Irish clinical psychologists about the desirability of mandatory CPD, mirrors the situation in other countries. For example, in the US, the controversy over mandatory CPD is an ongoing debate with some states requiring CPD for relicensure and others not (Hellkanp, Imm & Moll, 1989; VandeCreek & Brace, 1991). Mandatory CPD has not been established in the UK, Canada or Australia.

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 recent 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 mental handicap. 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). Furthermore, this broader role for clinical psychology and indeed for other psychologists in the health services has been highlighted in a PsSI occasional paper which discussed the application of psychology in health education, prevention, community based services, general medicine and services for the elderly (PSI, 1990).

Funding limitations precluded extending the survey described here beyond the Republic of Ireland to include Northern Ireland. For the results of such a survey to be meaningful, data sets from the Republic of Ireland and from Northern Ireland would require separate analyses or a comparative analysis since clinical psychologists in each of these contexts work within differing administrative structures. For such a survey, clinical psychologists in Northern Ireland could be identified through the BPsS Directory of Chartered Psychologists (BPsS, 1994). This is one potentially useful avenue for future work in this area. A second important future project arising from the present study is the replication of the survey in five years to track changes in the profession over time. Such replications have been fruitfully conducted in the US (Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b).

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27. What percentage of time do you usually spend in each of the following professional activities?	27 (a) Psychological treatment or psychotherapy % =	27 (b) Assessment and diagnosis % =	27 (c) Indirect work with clients via relatives or staff % =	27 (d) Research % =	27 (e) Teaching or training psychologists & other professionals % =	27 (f) Public education & preventative training % =
	27 (g) Routine Administration % =	27 (h) Service Planning % =	27 (i) Consultation % =	27 (j) Management of junior staff % =	27 (k) Receiving Supervision % =	27 (l) Other

Private Practice

28. Do you conduct a private practice?	Full time	Half time	As a part-time supplement to a main appointment.	No		
29. What premises do you use for private practice?	Main-employers premises	An office in your home	Consulting rooms	A private institute	Not Applicable	
30. Do you conduct your private practice alone or in a group?	Alone as an independent practitioner	As part of a group of psychologists	As part of a mixed group of practitioners	Not applicable.		
31. What percentage of your private practice is devoted to therapy?	% =					
32. What percentage of your private practice is devoted to assessment?	% =					
33. Are you insured against malpractice claims?	Through the BPsS	Through PPS	Other	Not Insured		
34. What are your average hourly Fees?	£20-30	£30-40	£40-50	£50-60	£60-100	£100+
35. Do you use a sliding scale to determine your private fees?	Yes	No				

Clinical Practice

36. Which of these theoretical orientations or models typically guides your work?	36 (a) Cognitive/ Behavioural	36 (b) Family systems	36 (c) Psychodynamic Psychoanalytic	36 (d) Humanistic/ Existential	36 (e) Eclectic/ Integrative	36 (f) Other

37. What percentage of your treatment time do you devote to each of the following treatment formats?	37 (a) Individual Therapy % =	37 (b) Family Therapy % =	37 (c) Group Therapy % =	37 (d) Couples Therapy % =	37 (e) Other % =	
38. What percentage of your assessment time do you devote to each of the following assessment procedures?	38 (a) Individual Clinical Interview % =	38 (b) Family clinical Interview % =	38 (c) Behavioural observation & analysis % =	38 (d) Intellectual Testing % =	38 (e) Neuro-psychological Testing % =	38 (f) Personality Testing % =

Research and Publications

39. How many articles have you published on psychological topics?	Number =
40. How many books have you published on psychological topics?	Number =
41. How many presentations have you made at psychology conferences?	Number =
42. How many pieces of research have you conducted ?	Number =

Career Satisfaction

43 (a). How Satisfied are your career as a psychologist?	Very Dissatisfied	Quite dissatisfied	Slightly dissatisfied	Slightly satisfied	Quite satisfied	Very satisfied
43 (b) . If you could choose your career again what would you choose?	Clinical Psychology	Another field of Psychology	Law	Business	Medicine	Other

44. Which **three** aspects of your job most contribute to your sense of **job satisfaction** ? (Please circle three of the factors listed here 45 (a) - 45 (x))	44 (a) Psycho-logical treatment or psychotherapy	44 (b) Individual Assessment and diagnosis	44 (c) Indirect assessment and treatment of clients via relatives or staff	44 (d) Research	44 (e) Teaching or training	44 (f) Routine Administration
	44 (g) Service Planning	44 (h) Con-sultation	44 (i) Manage-ment of junior staff	44 (j) Receiving Supervision	44 (k) The variety of tasks that make up my job	44 (l) Work load

	44(m)Adminis-trative resources	44 (n) Relation-ships with GPs	44 (0) Relation-ships with social workers	44 (p) Relation-ship with management	44 (q) Relationships with nurses	44 (r) Pay
	44 (s) Relation-ships with Physicians and surgeons	44 (t) Relation-ships with Psychiatrists	44 (u) Relation-ships with other psychologists	44 (v) Office Facilities	44 (w) Multi-disciplinary team work	44 (x)Other (Please specify)
45. Which **three** aspects of your job your job contribute most to stress at work or **job dissatisfaction**?	45 (a) Psychological treatment or psychotherapy	45 (b) Individual Assessment and diagnosis	45 (c) Indirect assessment and treatment of clients via relatives or staff	45 (d) Research	45 (e) Teaching or training	45 (f) Routine Administration
(Please circle three of the factors listed here 45 (a) - 45 (x))	45 (g) Service Planning	45 (h) Con-sultation	45 (i) Manage-ment of junior staff	45 (j) Receiving Supervision	45 (k) The variety of tasks that make up my job	45 (l) Work load
	45 (m)Adminis-trative resources	45 (n) Relation-ships with GPs	45 (0) Relation-ships with social workers	45 (p) Relation-ship with management	45 (q) Relation-ships with nurses	45 (r) Pay
	45 (s) Relation-ships with Physicians and surgeons	45 (t) Relation-ships with Psychiatrists	45 (u) Relation-ships with other psychologists	45 (v) Office Facilities	45 (w) Multi-disciplinary team work	45 (x)Other (Please specify)

Continuing Professional Development

46. Over the past year have you participated in any of these activities to continue your	46 (a) Part-time Degree course	46 (b) Part-time Diploma course	46 (c) Part-time certificate course	46 (d) Distance Learning Programme	46 (e) 1-2 day Skills Training Workshop	46 (f) Staff development workshop
professional development?	46 (g) Extramural Psychotherapy supervision	46 (h) Personal Psychotherapy	46 (i) Conference attendance	46 (j) Journal club or case presentations	46 (k) Reading professional literature	46 (l) Other

47. How much time/money do you allocate to CPD per year?	47 (a) Days per year =	47 (b) £s per year =				
48. How much time/money does your employer allocate to your CPD per year?	48 (a) Days per year =	48 (b) £s Per year =				
49. What type of CPD activities would you find most useful?	49 (a) Part-time Degree course	49 (b) Part-time Diploma course	49 (c) Part-time certificate course	49 (d) Distance Learning Programme	49 (e) 1-2 day Skills Training Workshop	49 (f) Staff development workshop
	49 (g) Extramural Psychotherapy supervision	49 (h) Personal Psychotherapy	49 (i) Conference attendance	49 (j) Journal club or case presentations	49 (k) Reading professional literature	49 (l) Other
50. What are the top three topics you would most like covered in your future CPD work?	Topic 1		Topic 2		Topic 3	
51. With respect to CPD, what role do you think PSI should take?	PSI should recommend CPD activities to Clinical Psychologists, but the choice of engaging in these should be up to each psychologist.	PSI should require clinical psychologists to complete certain CPD activities annually if they wish to receive a practising certificate.	Other			
52. Do you see personal growth work in the initial training of psychologists in clinical practice as	Essential	Desirable	Optional	Unnecessary		

53. Do you see personal growth work in the ongoing continuing professional development of psychologists in clinical practice as	Essential	Desirable	Optional	Unnecessary		

54. What specific events in your career as a psychologist has been most important to you and why were these events so important?

55. Have you any comments about the direction clinical psychology and related branches of psychology should take in Ireland in the next 10 years?

Thank you for your help. Please use the enclosed SAE to post the questionnaire back to me ASAP. The results of the survey will be available shortly.