



“Do you Think you Can?”: Self-Care and Personal Therapy in the  
development of Clinical Psychologists’ Self-Efficacy

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## **Resumo**

Imagine poder aumentar a sua confiança profissional simplesmente cuidando melhor de si mesmo. Tanto a investigação como a teoria corroboram a importância destes dois construtos no bem-estar de terapeutas. Assim, esta investigação teve como objetivo explorar a relação entre o autocuidado e a autoeficácia e, ainda, compreender quais as variáveis que podem influenciar cada um deles individualmente. A amostra foi composta por 207 psicólogos clínicos portugueses, utilizando um desenho correlacional transversal. Os resultados mostraram que os fatores de Desenvolvimento Profissional e Estratégias Cognitivas do autocuidado influenciaram a autoeficácia dos psicólogos. O Suporte Profissional e o Equilíbrio de Vida apresentaram uma correlação moderada com a autoeficácia. A experiência clínica e a terapia pessoal não apresentaram correlação significativa com a autoeficácia, enquanto que, ser mais velho e ter formação em psicoterapia demonstraram melhorar a autoeficácia. No que diz respeito ao autocuidado, a terapia pessoal não apresentou diferenças significativas, e praticar apenas psicologia clínica mostrou diminuir o autocuidado em termos de práticas profissionais. O estudo ressalta a importância das práticas de autocuidado no aumento da autoeficácia dos psicólogos clínicos e destaca a necessidade de mais pesquisa sobre os fatores que influenciam o uso de estratégias cognitivas no autocuidado.

Palavras-Chave: Autoeficácia; Autocuidado; Terapia Pessoal; Psicólogo Clínico; Terapeuta

## **Abstract<sup>1</sup>**

Imagine increasing your professional confidence as a therapist by simply taking better care of yourself. Both research and theory have corroborated the importance of these two constructs in therapists' well-being. Therefore, this investigation aimed to explore the relationship between self-care and self-efficacy, as well as understand what variables can influence them individually. The sample was composed of 207 Portuguese clinical psychologists, using a cross-sectional correlational design. The results showed that the Professional Development and the Cognitive Strategies factors of self-care influenced psychologists' self-efficacy. Professional Support and Life Balance both had a moderate correlation with self-efficacy. Clinical experience and personal therapy did not show any significant correlation with self-efficacy while being older and having training in psychotherapy was shown to improve self-efficacy. Regarding self-care, personal therapy didn't show significant differences, while practicing only clinical psychology showed to diminish self-care in terms of professional practices. The study underscores the importance of self-care practices in enhancing the self-efficacy of clinical psychologists and highlights the need for further research into factors influencing the use of cognitive strategies in self-care.

Key words: Self-efficacy; Self-care; Personal Therapy; Clinical Psychologist; Therapist

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## Introduction

Every clinician has had moments of doubt in their line of work, moments where they were not sure what course to take regarding a certain client, or even moments of regret because of something already said or done in the past. Nonetheless, psychologists need to have some level of confidence in their work, if not for the success of the client's treatment, for their own sense of achievement, and healthy relationship with their job. So, what makes some clinical psychologists more confident in their professional abilities than others?

This concept, self-efficacy, and the importance of the study of variables that influence it were described and explained by Bandura (1997) in his theory. In the authors' view, more self-efficacy means more resilience and optimism towards the task at hand. In contrast, less self-efficacy notes a person as avoidant and often feeling helpless (Bandura, 1977). This term was later applied to the perception of self-efficacy of psychologists, which relates to specific tasks of a psychologist's role (Lent et al., 2006), such as conflict with their clients, skills in insight, action, and exploration, dealing with their clients' moments of distress and managing the session at hand (Lent et al., 2003). Several studies point out that greater self-efficacy among therapists is fundamental to the success of the therapeutic process, bringing benefits not only to the therapists themselves (Lent et al., 2003; Lent et al., 2009) but also to their clients, in terms of psychological well-being outcomes (Heinonen et al., 2012).

Taking this into account, various studies have been conducted on variables that influence therapists' self-efficacy, the main three being: supervision, clinical experience, and training programs. Regarding the first, the results indicate that having good supervision leads to more self-efficacy (Morrison & Lent, 2018; Šefarová & Šlepecký, 2017). Secondly, the levels of self-efficacy seem to also be influenced by having participated in training programs (Ahn et al., 2022; Hill et al., 2008; Hill et al., 2016; Hill et al., 2020; Melchert et al., 1996; Mullen et al., 2015), although all studies refer to students and not practicing therapists. Finally, clinical experience has been poorly explored, the samples were mostly composed of psychology students (Li et al., 2022; Melchert et al., 1996; Tang et al., 2004) or health professionals in general (Gori et al., 2022). Nevertheless, the results seem to indicate that experience can impact self-efficacy,

even though the factors of supervision (Gori et al., 2022) and training (Melchert et al., 1996) show a bigger and more significant influence.

The other concept discussed in this study is self-care, more specifically, psychologists' self-care practices that promote both professional and personal well-being (Dorociak et al., 2017). Psychologists are, most likely, very aware of the importance of self-care and all its benefits to a person's mental and physical health, and stress mitigation (Daly & Gardner, 2022), since part of their job is to identify the areas of clients' lives in which they are not taking care of themselves. Thus, the question stands of why some psychologists do not practice self-care, at least not as much as they should, especially when this profession brings about specific challenges that could be considered draining (Rupert & Dorociak, 2019). In a study with 678 therapists from the UK, 62.7% affirmed they have had at least one psychological problem in their lives, anxiety and depression being the most common ones (Tay et al., 2018). Consequently, self-care practices have been studied as a way of attenuating stress and burnout in mental health professionals' lives (Rupert & Dorociak, 2019) as well as diminishing possible resulting risks for their clients (Di Benedetto & Swadling 2014). However, self-care practices have never been studied as methods to increase self-efficacy, with the exception of personal therapy, which is considered to be a way for self-care, and integrated into the general concept of self-care (Miller et al., 2023).

A largely debated topic in therapist communities to this day is the benefit of personal therapy for therapists themselves and, potentially, for their clients. The investigation surrounding this topic is mostly qualitative and ambiguous in its results (Grimmer, 2015). The study by Gold and Hilsenroth (2009) was one of the few quasi-experimental studies performed, the results indicating that even though clients' perception of session quality was unaffected by their therapists' self-efficacy, for the therapists themselves, their perception of self-efficacy was significantly higher for those that were in personal therapy. Other studies, presented some negative experiences from therapists who attended personal therapy, such as session cost and emotional commitment (Avis, 2011), as well as causing doubt and uncertainty in the therapists' professional identities (Noble & Rizq, 2019).

## **The present study**

Given the benefits of a psychologist having good self-efficacy and of having good self-care, it is important to know what causes the level of these constructs to vary in different individuals. The present study sought to add to the existing literature on both of these problems, by having a sample composed of solely practicing clinical psychologists instead of students and focusing on the interaction between these two constructs, as it has never been done before. Although there is literature regarding the effect of personal therapy on self-efficacy (Gold & Hilsenroth, 2009; Li et al., 2022), there are no studies on whether self-care influences self-efficacy, which proves to be contradictory, given that personal therapy, is considered a form of self-care (Miller et al., 2023). Therefore, this study proposes to investigate three main questions: (a) what demographic characteristics influence clinical psychologists' self-efficacy? (b) what demographic characteristics influence clinical psychologists' self-care? (c) Does self-care influence the development of clinical psychologists' professional self-efficacy?

## **Method**

### **Participants**

The participants in this study are Portuguese psychologists working in a clinical context, registered with the *Ordem dos Psicólogos Portugueses*. The criteria used to include participants is related to the area of training being clinical psychology, excluding people who are not currently practicing, and/or have not completed their training in psychology. This is a convenience sample, collected online via social media.

The average age of the participants is 35.36 years ( $SD = 10.33$ ), with most of the sample being women (81.2%) and single people (52.7%). People who are married or in a cohabiting relationship make up 39.1% of the sample and the remaining 8.2% correspond to divorced or separated people. In terms of employment status, 1.4% are unemployed, 13.5% have their own company, 15.9% have a fixed-term contract, 22.7% have an open-ended contract and, finally, 46.4% work on independent practice. Just over half of the sample receives between €10,000 and €20,000 per year (50.7%), then a percentage of 22.2% receives less than €10,000, 16.9% receives between €20,000 and €30,000, 3.9% between €30,000 and €40,000, another 3.9% between €40,000 and €50,000 and only 2.4% receive more than €50,000 annually.

Most of the sample consists of non-psychotherapists (67.1%), and of people who work only with clinical psychology (52.7%). More than half of the participants are in supervision (61.4%). The sample had an average of 28.8 hours dedicated to clinical psychology per week ( $SD = 13.48$ ). In regard to having personal therapy, the majority of participants are not in therapy at the moment (56.5%) but have been in therapy in the past (72.0%). In general, the duration of therapy, whether present or past, has an average of 4.06 years ( $SD = 4.83$ ). Regarding the final score after completing the master's degree, the average found was of 15.8 ( $SD = 1.4$ ). We can verify that the sample is therefore made up of good students. Regarding years of experience in clinical practice, the average was 8.46 years ( $SD = 8.50$ ), however, a large part of the sample (37.2%) has between zero and two years of experience. Regarding the therapeutic orientations of the participants, we were able to group them into five different models: Cognitive-Behavioral (44.93%), Psychoanalytic/Dynamic (22.71%), Integrative/Eclectic (17.39%), Systemic/Family (7.25%), Existential/Phenomenological (3.86%) and Others (3.86%).

### **Instruments**

***Counselor Activity Self-Efficacy Scales (CASES)***: The Counselor Activity Self-Efficacy Scales (CASES) (Lent et al., 2003) is conceptually divided into three parts: Helping Skill, Session Management and Counseling Challenges. Within the Helping Skill subscale, the authors identified 3 factors, namely Insight Skills (6 items), Exploration Skills (5 items) and Action Skills (4 items). Session Management is in itself considered a factor (10 items) and, regarding Counseling Challenges, the factors Relationship Conflict (10 items) and Client Distress (6 items) were found. This is a self-report scale, whose purpose is to measure the perception that clinical psychologists have of their self-efficacy as professionals. Composed of 41 items organized on a Likert scale from 0 to 9 (0 - no confidence; 9 - a lot of confidence). In this study, the Portuguese version of Laires and Conceição (2012) was used.

Regarding psychometric properties, Cronbach's alpha for the total scale is .97, which is an indicative value of good internal consistency. Additionally, each isolated factor also presented high parameters: Exploration Skills (.79), Insight Skills (.85), Action Skills (.83), Session Management (.94), Client Distress (.94), Relationship Conflict (.92) (Lent et al., 2003). In the present investigation, the alpha values were, for the total scale .95, for the Exploration Skills subscale .89, for the Insight Skills subscale .80, for the

Action Skills subscale .76, for the Session Management subscale .93, for the Client Distress subscale .92, for the Relationship Conflict subscale .89. Therefore, the scale and subscales have good reliability.

***Escala de Avaliação de Autocuidado para Psicólogos (EAAP):*** The original scale is called the Self-Care Assessment for Psychologists Scale (SCAP) (Dorociak et al., 2017) and was adapted for the Portuguese population by Reis (2020), to evaluate the self-care of clinical psychologists. The *Escala de Avaliação de Autocuidado para Psicólogos (EAAP)* (Reis, 2020), is a self-report questionnaire composed of 21 items on a 7-point Likert scale from 1 to 7 (1- Never; 7 - Always), on which the participant is asked to answer how often they perform the behavior described in each item.

This instrument presents 5 factor scales, all with a high level of internal consistency: Professional Support ( $\alpha = .86$ ), Professional Development ( $\alpha = .83$ ), Life Balance ( $\alpha = .88$ ), Cognitive Strategies ( $\alpha = .84$ ) and Daily Balance ( $\alpha = .70$ ) (Reis, 2020). In the present investigation, the alpha values were, for the Professional Support subscale .85, for the Professional Development subscale .81, for the Life Balance subscale .87, for the Strategies subscale Cognitive .78, for the Daily Balance subscale .83. Therefore, the subscales have good reliability.

## **Procedure**

The instruments were distributed through an online questionnaire using the Google Forms platform, being disseminated through social networks (Linked In, WhatsApp, etc.).

Initially, the informed consent form is presented in the questionnaire (Annex C), which describes all the necessary information about the study: general objective, instruments used, inclusion criteria, and important contacts. The confidentiality of the data provided, as well as the identification of each participant, was also reinforced. Next the sociodemographic questionnaire appears, with the aim of obtaining information about the participants that may be relevant to the study. Therefore, each participant is asked to indicate their gender, age, marital status, their final average score at the end of their master's degree, their therapeutic orientation, whether they have training in psychotherapy, their years of experience in clinical practice, the number of hours they dedicate to practicing Clinical Psychology per week, whether they work in areas other than Clinical Psychology, their employment status, annual income, whether they have

supervision and whether they have at the moment or have had personal therapy in the past and the duration of it. Finally, the Counselor Activity Self-efficacy Scales (CASES) (Lamares & Conceição, 2012) and the Self-Care Assessment Scale for Psychologists (EAAP) (Reis, 2020) appear.

### **Statistical Analysis**

The present study has a cross-sectional correlational design (Barker et al., 2002). The statistical package SPSS - v. 29.0 was used and the significance level used was  $\leq .05$ . Since the sample under study contains  $n > 30$ , it was considered that all variables follow a distribution that is at least satisfactorily approximate to normal, according to the Central Limit Theorem (Maroco, 2006). Cronbach's alpha was calculated for the totals of the self-efficacy (CASES) and self-care (EAAP) scales, as well as for their subscales, in order to verify the reliability of the instruments.

In order to characterize the sample under study, descriptive statistics analyses were carried out. Additionally, given that the self-care scale (EAAP) does not present a total score, Pearson correlations, t-student tests, one-way ANOVAS and a Kurskal-Wallis test were performed in order to understand the associations between sociodemographic variables and each EAAP factor. The ANOVAS' assumption of homogeneity of variances is met (Annex D), as are the ANCOVA's assumptions (Annex E). For self-efficacy, the total CASES score was used, and, in the same way as for self-care, Pearson correlations, t-student tests, and one-way ANOVAS were performed. An ANCOVA was also carried out. The assumptions of these tests were also met (Annex F). Regarding multiple linear regressions, for both models, the assumptions of normality, zero mean and homogeneity of errors were met. The assumption of non-multicollinearity is also met since the VIFs are not greater than 5 (Maroco, 2006). To test the independence of residues, the Durbin-Watson test was used, which presents as close enough to 2 (Maroco, 2006). Attached (Annexes G and H) are the outputs necessary to verify the assumptions.

## **Results**

### **Predictors of Self-Care**

In trying to predict self-care variances, we assessed the influence of sociodemographical variables such as age, annual income, marital status and employment status. Variables regarding clinical experience and formation in psychology were also assessed with the participants final score at the end of the master's degree, years of clinical

experience, hours of clinical work a week, if the participants practice only clinical psychology or other types, and if they have training in psychotherapy. Lastly, past and present personal therapy were also analyzed, as well as its' duration.

Regarding the age of the subjects, the only significant correlation found, although weak, was with the Professional Development factor ( $r(205) = .17, p = .018$ ). The final score at the end of the master's degree and the duration of personal therapy did not show significant correlations with any of the factors. Clinical hours per week demonstrated a moderate negative correlation for the Daily Balance factor ( $r(204) = -.34, p < .001$ ), which reveals that the more working hours dedicated to practicing clinical psychology, the lower the balance of the participants in their day-to-day lives.

Years of experience in clinical practice correlated positively and weakly with the Professional Support factor ( $r(202) = .16, p = .026$ ) and the Professional Development factor ( $r(202) = .20, p = .004$ ). In relation to annual income, there was a weak positive correlation for the Professional Support factor ( $r(205) = .15, p = .026$ ) and, also, a weak positive correlation for the Professional Development factor ( $r(205) = .18, p = .008$ ). However, age may be influencing these results, in the sense that older people are more likely to have more years of experience and a higher income. Thus, four partial correlations were made between: Professional Development and years of experience ( $r(201) = .11, p = .125$ ); Professional Development and annual income ( $r(204) = .12, p = .080$ ); Professional Support and years of experience ( $r(201) = .13, p = .062$ ); Professional Support and annual income ( $r(204) = .13, p = .070$ ). None of the correlations were significant, which indicates that the age variable was, in fact, influencing the results (Table 1).

Having training in psychotherapy did not reveal significant differences between groups for any of the EAAP subscales. As seen in Table 2, regarding working only in clinical psychology or with other areas of psychology, differences were found for the Professional Support factors ( $t(194.812) = -2.101, p = .037, d = .287$ ) and Professional Development ( $t(202.939) = -3.428, p < .001, d = .472$ ). Thus, participants who work in roles other than clinical psychology have better professional support ( $M = 29.000$ ) than those who work only in clinical practice ( $M = 27.468$ ). Also, participants who perform functions other than clinical psychology have better professional development ( $M = 29.531$ ) than those who only practice clinical practice ( $M = 27.275$ ).

**Table 1**

*Correlations between EAAP subscales (Professional Support, Professional Development and Daily Balance) and relevant variables (Years of Experience, Annual Income, Age and Clinical Hours per Week)*

Variables	n	M	SD	1	2	3	4	5	6	7
1. Professional Support	207	28.193	5.373	-						
2. Professional development	207	28.243	4.900	-	-					
3. Daily Balance	207	14.604	4.028	-	-	-				
4. Years of Experience (control for age)	204	8.463	8.510	.131	.108	-	-			
5. Annual Income (control for age)	207	2.237	1.120	.126	.122	-	-	-		
6. Age	207	35.362	10.324	-	.165*	-	-	-	-	
7. Clinic Hours per Week	206	28.803	13.476	-	-	-.337*	-	-	-	-

*Notes: \*Statistically significant at the .05 level*

**Table 2**

*Association of the EAAP subscales (Professional Support and Professional Development) with the variable Clinical Only or Other.*

<b>Variables</b>	<b>t</b>	<b>gl</b>	<b>p-value</b>	<b>d-cohen</b>
Professional Support	- 2,101	194,812	.037*	.287
Professional Development	- 3,428	202,939	< .001*	.472

*Notes: \*Statistically significant at the .05 level*

Additionally, significant differences were found for Life Balance ( $t(205) = 1.990$ ,  $p = .048$ ,  $d = .279$ ) regarding current personal therapy in which, contrary to expectations, those who are not in personal therapy at the moment ( $M = 25.265$ ), have a better Life Balance than those who are ( $M = 24.378$ ). However, the results do not tell us whether people with a better Life Balance are not in personal therapy because they have had it in the past and have already finished their process, or if they have never had therapy at all. Therefore, it was decided to divide the participants into four categories of a new variable called “Personal Therapy”: People who had therapy in the past and present; People who had it in the past but do not have it in the present; People who did not have it in the past but have it in the present; People who did not have it in the past or in the present. With this variable, a one-way ANOVA was carried out, which revealed the absence of significant differences between groups ( $F(3,203) = 1.496$ ,  $p = .217$ ,  $\eta_p^2 = .022$ ). No tests were carried out regarding supervision, since the self-care items, particularly in the professional support section of the EAAP, directly ask whether the participant maintains contact with professional colleagues.

Regarding the marital status of the participants, differences were found between groups in the levels of Professional Support ( $F(2,204) = 4.996$ ,  $p = .008$ ,  $\eta_p^2 = .047$ ). The size of the effect is, however, small (Maroco, 2006). Using Tukey's test (95% CI ] 0.415, 4.067 [,  $p = .012$ ), we were able to verify that significant differences are evident between psychologists who are married or cohabiting with a partner ( $M = 29.617$ ) and single psychologists ( $M = 27.376$ ). However, married people are more likely to be older than single people, which led to an ANCOVA. Thus, when age is added as a covariate, the differences between groups remain significant ( $F(2,203) = 4.197$ ,  $p = .016$ ,  $\eta_p^2 = .040$ ).

The assumption of homogeneity of variances was not met for the ANOVA between the employment status and the Professional Development score, which led to a non-parametric Kruskal-Wallis test, according to which there are no significant differences between groups ( $X_{KW}^2(4) = 2.898, p = .575$ ).

### **Predictors of Self-Efficacy**

We were able to verify that, regarding age, a moderate positive correlation was found with self-efficacy ( $r(205) = .32, p < .001$ ), indicating that the older the psychologists are, the more self-efficacy they have. These results were controlled for years of experience, through a partial correlation, which demonstrated the maintenance of a significant positive correlation, although weak ( $r(205) = .14, p = .040$ ). In terms of gender, there are no significant differences between the average self-efficacy of men and women.

Additionally, two weak positive correlations were found between years of experience in clinical practice and self-efficacy ( $r(202) = .29, p < .001$ ) and annual income and self-efficacy ( $r(205) = .26, p < .001$ ). However, two other partial correlations were carried out, controlling for the covariate age, since it is more likely that older people have more years of experience and a higher income. After this adjustment, neither years of experience in clinical practice ( $r(201) = .05, p = .514$ ) nor annual income ( $r(204) = .13, p = .069$ ) showed significant correlations with self-efficacy. Both the final average score of the master's degree, the hours dedicated to clinical psychology per week, and the duration of personal therapy, did not show significant correlations with self-efficacy.

Regarding the marital status and therapeutic orientation of the participants, they did not show significant differences in the levels of self-efficacy in the various groups. In the employment status, significant differences were found ( $F(4,202) = 2.800, p = .027, \eta_p^2 = .053$ ), with an effect size considered very high (Maroco, 2006). These differences were found, using the Tukey test (95% CI)  $-63.955, -4.244$  [ $p = .016$ ], between psychologists who have a fixed-term employment contract ( $M = 260.758$ ) and psychologists who have their own company ( $M = 294.857$ ). However, as we saw previously, age has a significant correlation with self-efficacy and, in this case, it would be more likely that a person with their own business would be someone older. Therefore, an ANCOVA was performed to control for the age of the participants, which demonstrated that the covariate age has an effect on self-efficacy ( $F(1,201) = 15.621, p < .001, \eta_p^2 = .072$ ). The statistics also revealed

that, after controlling for age, there is no effect of the employment relationship on self-efficacy ( $F(4,201) = 1.212, p = .307, \eta_p^2 = .024$ ).

No differences were found between psychologists who only practice clinical psychology and psychologists who also work in other areas of psychology, as we can see in Table 3. Additionally, psychologists with or without supervision did not show significant differences in levels of self-efficacy. Having personal therapy either in the present or in the past also proved to be insignificant. However, having training in psychotherapy demonstrated significant differences in the participants' level of self-efficacy ( $t(205) = -2.054, p = .023, d = .304$ ), with a medium effect size (Maroco, 2006). Thus, psychotherapists have a higher level of self-efficacy ( $M = 286.265$ ) when compared to non-psychotherapists ( $M = 273.309$ ).

**Table 3**

*Association of sociodemographic variables (Gender, Clinical Only or Other, Supervision, Present Personal Therapy, Past Personal Therapy, Psychotherapist or Non-Psychotherapist) with the total CASES score.*

<b>Variables</b>	<b>N</b>	<b>t</b>	<b>gl</b>	<b>p-value</b>	<b>d-cohen</b>
Gender	207	- 1,620	205	.107	.288
Only Clinic or Other	207	.315	205	.753	.044
Supervision	207	1,314	205	.190	.188
Present Personal Therapy	207	1,579	205	.116	.221
Past Personal Therapy	207	- .010	205	.992	.002
Psychotherapist or Non-psychotherapist	207	- 2,054	205	.023*	.304

*Notes: \*Statistically significant at the .05 level*

Focusing on each EAAP subscale (Table 4), all correlations with the CASES total score were positive, with moderate correlations in Professional Development ( $r(205) = .37, p < .001$ ), Life Balance ( $r(205) = .32, p < .001$ ) and Cognitive Strategies ( $r(205) = .49, p < .001$ ). The correlation with the Professional Support subscale ( $r(205) = .27, p <$

.001) was weak, and the correlation with Daily Balance ( $r(205) = .09, p = .200$ ) was not statistically significant.

**Table 4**

*Correlations between the EAAP subscales (Professional Development, Life Balance, Cognitive Strategies, Professional Support, Daily Balance) and the total CASES score*

<b>Variables</b>	<b>r</b>	<b>p-value</b>	<b>Classification</b>
Professional development	.37	< .001*	Moderate
Life Balance	.32	< .001*	Moderate
Cognitive Strategies	.49	< .001*	Moderate
Professional Support	.27	< .001*	Weak
Daily balance	.09	.200	—

*Notes: \*Statistically significant at the .05 level*

### **Explanatory Model of Self-Efficacy**

Initially, a multiple linear regression was carried out with the five EAAP subscales as predictors and the total score of CASES as the dependent variable, using the enter method, for an initial assessment of the results (Table 5). The model (Model 1) is considered statistically significant ( $F(2,205) = 15.888, p < .001, R_a^2 = .265$ ) and explains 26.5% of the variance in self-efficacy. Additionally, the Professional Development factor ( $\beta = .206, t(201) = 2.726, p = .007$ ) and the Cognitive Strategies factor ( $\beta = .388, t(201) = 5.635, p < .001$ ) presented statistical significance, with the latter being the best predictor. These results are in agreement with the Pearson correlations seen previously.

**Table 5**

*Model 1 - Multiple Linear Regression for the predictors (EAAP subscales) of Self-Efficacy (CASES)*

<b>Predictors</b>	<b>B</b>	<b>IF</b>	<b>Beta</b>	<b>p-value</b>
Constant	42.263	27.622		.128

Professional Support	-.058	.595	-.007	.922
Professional development	1.805	.662	.206	.007*
Life Balance	1.029	.994	.077	.302
Cognitive Strategies	6.678	1.185	.388	< .001*
Daily Balance	-.357	.680	-.033	.601

Notes: \*Statistically significant at the .05 level

However, the age variable demonstrated a moderate correlation with self-efficacy as we saw previously. Thus, the stepwise method of inserting variables into the model was used to verify whether, by retaining only the significant variables and adding age as a predictor, the value of  $R_a^2$  would increase and improve the quality of the model. However, this model, despite being statistically significant ( $F(3,200) = 34.805, p < .001, R_a^2 = .333$ ), did not present a major improvement in quality.

## Discussion

### Self-efficacy

When associating the various factors of self-care with self-efficacy, the regression model showed that a percentage of self-efficacy is explained by these factors, even though it is a low percentage. While this value may seem modest, it is important to contextualize this within the field of psychology, where lower adjusted R-squared values are common due to the multifaceted nature of human behavior and the multitude of influencing factors (Ozili, 2023). Hence, one can conclude that taking care of ourselves by engaging in self-care practices, both personally (Cognitive Strategies) and professionally (Professional Development), can increase confidence in one's professional abilities as a clinical psychologist. Interestingly, Cognitive Strategies, composed of being able to read and monitor one's own feelings, thoughts, and needs and act upon them, showed the biggest predictive value of self-efficacy. This raises the question of whether psychologists perceive that if they are good at applying these skills to themselves, they are also good at applying said skills to their clients. This factor was also one that did not

correlate with any of the variables tested in the analysis, in terms of what can influence self-care. Given the importance of its predictive value of self-efficacy, future research should investigate factors that impact the use of cognitive strategies in psychologists' own self-care.

In agreement with the study by Li et al. (2022), age was demonstrated to be a relevant factor in building the self-efficacy of clinical psychologists. It could be argued that older psychologists probably have more experience, which is the real variable that is influencing self-efficacy. However, this study controlled for the effects of experience, and age remained relevant even though the correlation fell from moderate to weak. This indicates that even a psychologist who decided to train in clinical psychology later in their life, will, in principle, have greater self-efficacy due to their older age, when compared to their younger peers. Although age can't be manipulated to obtain greater self-efficacy, one can wonder if this could be related to having more life experience in general. Or it could perhaps be due to societal ideas that younger people are less competent. Future studies could try to pin the underlying factor behind age that makes older psychologists perceive themselves as more efficacious.

Experience, one of the methods of obtaining self-efficacy described by Bandura (1977), was measured in this study through years of practice and hours of clinical practice per week. Contrary to theory, but according to studies carried out (Melchert et al., 1996; Gori et al., 2022), none of these variables proved to be relevant to the participants' levels of self-efficacy. Furthermore, additional training, in this specific case, training in psychotherapy, was shown to provide psychologists with more self-efficacy, also in line with the study by Ahn and collaborators (2022). In this way, the results are very similar to those of Melchert and collaborators (1996), validating, almost three decades later, the importance of additional training for these professionals, even above the importance of experience in the field. Lent et al. (2003, 2006, 2009) present a possible explanation for why overall clinical experience doesn't influence the levels of self-efficacy, and that is that self-efficacy varies on the same therapist with each client they have, according to the specific problems and traits of the client. The idea is that every client presents itself as so unique, that having had previous experience working with other clients will not be of relevance to help this specific client. In this sense, only experience and time with said client would be beneficial for the therapists' self-efficacy, which is why the authors decided to study client-specific self-efficacy. In this study we measured general self-

efficacy and, as it was presented, it does not seem to vary with experience, hence, the focus on specific self-efficacy might need to be further explored in future studies.

In terms of therapeutic orientation, one could expect greater self-efficacy from cognitive-behavioral therapists since some studies indicate greater effectiveness of this type of therapy, in terms of client outcomes and recovery, at least for certain disorders (Cuijpers et al., 2023). However, professionals do not seem to use these more rational and general data as determinants of their abilities as individuals, since self-efficacy does not seem to vary according to the therapist's theoretical orientation. Likewise, the average score at the end of the master's degree did not show any relationship with self-efficacy. Supposably, a student with better grades will have a greater knowledge and understanding of human behavior and what is necessary to be a good psychologist, even if it is in an almost exclusively theoretical way. However, the results suggest that this theoretical understanding is not relevant to cause differences in psychologists' self-efficacy levels. It is also important to note that the final average score is, in reality, a number that tries to summarize years of study and learning, that holds much more complexity than just a final score. Perhaps this is why this variable does not seem to be relevant in the development of self-efficacy.

Regarding present and past personal therapy and its duration, the results challenge the assumption that psychologists' self-efficacy is closely linked to their personal therapeutic experiences as clients (Bennett-Levy, 2019). Contrary to some studies (Gold & Hilsenroth, 2009; Li et al., 2022), none of the variables had any significant influence on self-efficacy, either in terms of increasing it or diminishing it. Although personal therapy is often recommended for managing stress and preventing burnout, its role may be more aligned with psychologists' personal well-being than their perception of professional effectiveness. Given these results, training programs may need to reconsider the emphasis on personal therapy as a mandatory component and, instead, redirect resources to improving other elements of training, such as training in specific skills.

Additionally, supervision did not show any significant correlation with self-efficacy, contrary both to theory and previous studies conducted (Lohani & Sharma, 2023; Šefarová & Šlepecký, 2017). These results could be explained by the idea that what matters in supervision in terms of building the supervisee's self-efficacy is not so much if they are having it or not, but the quality of the relationship between them and their

supervisor, as Morrison and Lent (2018) studied. Quality of supervision and of personal relationships within that supervision is a whole other scientific research area that brings about a lot of complexity and challenges. Nonetheless, this study corroborates the importance of the continuity of its understanding, having in mind the goal to improve training systems for future therapists.

### **Self-care**

In regards to the results on self-care, some of the findings ought to be expected, like the indication that more hours of work mean less daily balance, and that age influences the professional development aspect of self-care. The most interesting finding is that, although personal therapy is considered by some authors as an integral part of self-care practices (Miller et al., 2023), the results reveal that being in personal therapy, whether in the present or in the past, does not have a significant impact on the level of self-care of psychologists in its various domains. According to the discussion on personal therapy's influence on self-efficacy, and the idea that personal therapy serves psychologists at a personal level but not so much at a professional one, it is understandable the lack of influence of self-care in the Professional Support and the Professional Development domains. However, not even in the more personal aspects of self-care did personal therapy have an impact. This raises important questions about the assumptions underlying the promotion of personal therapy as inherently enhancing of one's ability to manage self-care. Other factors, such as inherent personality traits or external support systems might play a more crucial role in determining self-care practices and, consequently, should be the target of more investigation.

The results also suggest that people who work only in clinical psychology seem to engage in less Professional Support and Professional Development activities. The variety of tasks and interactions encountered in non-clinical roles might provide a broader range of coping mechanisms, networking, social abilities, and less isolation, which allows for more self-care strategies to be practiced in the workplace. Conversely, the intense, often emotionally taxing nature of clinical work may limit self-care opportunities and lead to higher stress levels. These results underscore the importance of diversifying professional activities and integrating varied experiences to promote better self-care among psychology professionals.

In summary, this study can provide valuable insights into effective strategies to strengthen the confidence and, consequently, the competence of clinical psychologists, improving their job satisfaction and the clinical outcomes of their clients.

### **Limitations**

One of the limits of this study refers to the impossibility to generalize this data due to the sampling method used in this study (convenience). A large number of participants were white women from Lisbon who were of cognitive-behavioral therapeutic orientation. Thus, this bias in sampling can originate different results if applied to a more rural, culturally different, and multi-oriented population. Another concern is that both self-efficacy and self-care are measured through self-report, which means the results are always subjective to the individuals' own perception, having no way of comparing whether this perception fits reality or not.

### **Professional Implications**

In general terms, this study provides important information on the improvement of psychologists' well-being and job performance. Taking this into account, it is in the entities that provide training for these professionals' best interest to promote self-care practices among students/trainees, helping them to integrate these into their daily routines in order to increase the chance of maintenance during their careers.

Additionally, therapists and the mental health community should strive for more connection and shared information and experiences between professionals. Diminishing the isolation sometimes caused by this profession, especially in clinical practice in private offices, is essential to the better development of good psychologists. Also, the community should encourage students/trainees to pursue any professional orientation they desire and relieve some of the pressure on having excellent grades, as was shown in this study that the impact of those variables is non-significant. Additional and continuous training, such as psychotherapy training should be encouraged as well in all stages of one's career, due to the ever-changing nature and complexity of the practice. Finally, regarding personal therapy, as results indicate a lack of impact of this variable both on self-efficacy and on self-care, the focus and obligation to carry out the practice in training programs should be revised.

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## **Annexes**

## **Annex A - Literature Review**

### Self-efficacy - The Construct

The concept of self-efficacy was described by Bandura (1977) as the belief that an individual has in their own ability to successfully perform and achieve a specific task or a certain goal. This construct, then, relates to the perception that each individual has of their capabilities and not to their actual real abilities.

The author theorizes that there are, in general, four ways to obtain self-efficacy. The first being success in performance, in which the person experiences the task for themselves and, by managing to perform it, ends up gaining more and more confidence that they can do it. Secondly, we have vicarious experience or vicarious learning, in which the individual sees another person performing the task successfully and, in comparison to that same person, comes to believe that they are also capable of carrying out the task. Next, Bandura (1977) presents us with the strategy of verbal persuasion in which, as the name suggests, third parties encourage the individual about their abilities related to the task, even though this may have a smaller impact on the perception of self-efficacy. Finally, an individual's physiological and emotional states can alter the perception of their capabilities at a given moment, that is, if the person is altered and not in their normative state, they may think they will perform worse. Despite this, the conclusions to be drawn are not always so linear and we need to take into account the surrounding context of the person and the situation itself. (Bandura, 1977).

Additionally, according to the author, individuals with high self-efficacy are more likely to be optimistic and resilient when faced with challenges and to actively persist in the face of them. On the other hand, people with low self-efficacy may end up avoiding tasks they find challenging and be more prone to feelings of helplessness. (Bandura, 1977).

This concept remains very current and is still applied in modern days. Ozer (2023) tried to understand the role of self-efficacy in perceived stress and life satisfaction during the pandemic caused by the COVID-19 virus, in a sample of university students. The results showed that the greater the students' self-efficacy, the lower their perceived stress and the greater their life satisfaction. This research corroborates the theory that, faced

with a challenge, people with a greater belief in their abilities (ie. greater self-efficacy) will perceive the situation as more positive and less stressful.

### The Self-Efficacy of Psychologists

Many of Bandura's (1977) hypotheses about self-efficacy theory can also be applied to the perception of self-efficacy of psychologists, which relates to specific tasks of a psychologist's role (Lent et al., 2006). Larson and Daniels (1998) define the self-efficacy of therapists, in general, as “the beliefs or judgments they have about their ability to help a client effectively in the near future”.

This construct is considered multidimensional, having several facets to be considered, and may vary over time and from situation to situation. This is because helping clients is something subjective to each client that appears in a clinical context and the way in which they help differs in each situation and context, which requires skills such as: establishing a relationship with clients, assessing, diagnosing and carrying out interventions in an appropriate, adapt therapy to the changes and ruptures that may occur and achieve the goals established with the client (Larson & Daniels, 1998). Since the 1980s, psychologists' self-efficacy has been the target of several scientific investigations, being referred to as “counselor self-efficacy” (CSE) (Melchert et al., 1996; Larson & Daniels, 1998; Lent et al., 2006; Li et al., 2022) and as “trainees’ self-efficacy” (TSE) (Lent et al., 2009) when referring to therapists in training. But how important is it to study the reasons that lead psychologists to believe more or less in their abilities as therapists? Several studies point out that greater self-efficacy among psychologists is fundamental to the success of the therapeutic process, bringing benefits not only to the psychologist himself (Lent et al., 2003; Lent et al., 2009) but also to his clients, in terms of psychological well-being outcomes (Heinonen et al., 2012).

Regarding psychologists, Lent and collaborators (2003), when developing the self-efficacy scale for psychologists (CASES), discovered that the therapist's interest related to the profession, choice and affective experience during the therapeutic process are influenced by their level of self-efficacy. Specifically for therapists in training, the results of the study by Lent et al. (2009) point out that self-efficacy has an impact on reducing anxiety, greater positive affect and, even, better performance of skills during

therapy. In theory, if greater self-efficacy leads to more interested, less anxious and more competent psychologists, this will lead to better and greater gains for clients in therapy (Lent et al., 2009). However, the results of the study also indicate an only indirect influence of the self-efficacy of therapists in training on the quality of the session perceived by clients (Lent et al., 2009). Additionally, the results of the study by Heinonen et al. (2012) partially corroborate the theory, as patients in short-term therapy from therapists who identified themselves as being more invested and/or effective, experienced a significantly faster decrease in symptoms. However, in long-term therapy, how therapists identified themselves did not have a significant impact on symptom reduction. In this way, it is possible to understand the complexity of these various relationships that are interconnected, between the therapist's perception of self-efficacy, the client's perception of therapy effectiveness and the client's outcomes measured through symptom reduction.

That said, several factors that influence the self-efficacy of psychologists have been studied over time. In terms of age, the results of the longitudinal study by Li et al. (2022) with 103 Chinese therapists in training (master's students), demonstrated that the older the therapists, the greater their initial self-efficacy (ie before they began to have clinical experience). The same study also demonstrated that female therapists had lower initial levels, and at the same time, they obtained the greatest increase in self-efficacy during the two years in which they were evaluated. However, other studies found no relationship between participants' age, gender and self-efficacy (Tang et al., 2004; Mullen et al., 2015; Saleem et al., 2022), leaving some ambiguity regarding the effect of these variables.

Supervision has also been studied as an influential factor in therapists' self-efficacy, as it is seen by many as an essential means of developing the knowledge and skills necessary for good therapy practice (Lohani & Sharma, 2023). Šefarová and Šlepecký (2017) conducted a study with 125 psychotherapists in supervision, of which 67 were therapists in training and 58 had recently completed their training in psychotherapy. The results demonstrated that the better the supervision was evaluated by the supervisees, the more self-efficacy the participants had. Morrison and Lent (2018) evaluated another aspect of supervision other than supervisees' perception of its quality. The results indicate that self-efficacy was greater in supervisees who believed that their

supervisor saw them as more competent and, also, in those who believed that their supervisor was an excellent clinician. In general, the alliance between supervisor and supervisee was one of the key factors for developing good self-efficacy (Morrison & Lent, 2018).

Additionally, positive and successful experiences are one of the most effective ways to increase self-efficacy according to Bandura's theory (1977), as they reinforce with empirical evidence that the person is capable of carrying out a certain task. Therefore, the hypothesis is that the higher the level of clinical experience of psychologists (measured in number of years, months or hours), the greater the self-efficacy of psychologists. In this sense, investigation of the influence of experience is scarce and most studies only use samples of psychology students and do not include practicing psychologists (Li et al., 2022; Tang et al., 2004). Melchert and collaborators (1996), at the time, tried to respond to this lack in the research by including practicing psychologists, however, they only managed to get 5% of the sample to be made up of this population, with the rest of the participants being psychology students. Still, they controlled the results to study the specific influence of clinical experience and found evidence that the level of training students receive represents a greater part of the variance in self-efficacy scores than their level of clinical experience. The results of the study also point to the fact that having more hours of clinical experience per week does not contribute to greater self-efficacy, which refutes the idea of this positive relationship between experience and self-efficacy, which initially seemed so obvious. Consistent with these findings, in the study by Morrison and Lent (2018), the supervisory relationship proved to be more relevant than years of experience in determining therapists' self-efficacy, even though it played a significant role. More recently, Gori and colleagues (2022), in their study with 322 mental health professionals (37.6% were psychologists), obtained results that indicate that there is no difference in the level of self-efficacy based on the length of clinical experience.

Perhaps this is why subsequent research has focused on evaluating therapist training programs, as they provide tools to learn skills that are not possible to acquire simply through more experience in the clinical context. Thus, most literature focuses on evaluating the influence that specific training programs have on psychology students or beginning psychologists (Hill et al., 2008; Mullen et al., 2015; Hill et al., 2016; Hill et al.,

2020; Ahn, et al., 2022). Also, as Li and collaborators (2022) point out, this population has greater doubts about their capabilities as psychologists, probably because they have never had contact with clinical practice, or it is quite limited, and are throwing themselves into their profession. The study by Ahn and collaborators (2022) evaluated 551 students who took an extra-curricular course in helping skills and the results demonstrated an increase in the participants' self-efficacy levels after completing the course.

Part of the research on therapists' self-efficacy focuses on understanding how this construct varies when assessed in a specific context, with certain conditions and in one or more particular performances. Bandura (1977), in his theory, describes three distinct levels of self-efficacy: specific, intermediate and general. Lent et al. (2009), propose that different aspects of self-efficacy are reflected when it is assessed at these different levels, and when assessing a more specific level of self-efficacy, the results obtained are also more specific in terms of the factors that influence it. Regardless of whether they are younger or older psychologists, with less or more experience, Lent and colleagues (2003) believe that the perception of self-efficacy varies in the same psychologist depending on the client they have in front of them, or the topic being worked on at that moment. . Thus, general self-efficacy (GSE) is more suitable for studying variations in self-efficacy over time and for comparing levels of self-efficacy between psychologists, while specific self-efficacy (SSE) is more suitable for analyzing differences in the therapist or client who make the levels of self-efficacy vary (Hu et al., 2014). Corroborating the theory, research points to the fact that the therapist's self-efficacy increases with each session that therapists have with a given client (Lent et al., 2006; Lent et al., 2009).

Hu and colleagues (2014) also tried to understand which specific factors in session influence the perception of 43 Chinese therapists that they are doing a good job in their profession. The results indicated that these factors are: the therapeutic alliance, more specifically the establishment and understanding of therapy tasks and objectives, and also how deep and positive the sessions are. Additionally, 61% of participants in the study by Lent and colleagues (2009) identified indirect feedback from clients about the sessions (ie behavior, cognitions and feelings) as a factor impacting their self-efficacy and 33% mentioned their perception of the therapeutic relationship. Regarding the factors “physiological or affective state of the psychologist in training”, “direct feedback from

clients”, “perceptions of the session process or outcome” and “supervision effects”, low causality was attributed to them.

### Self-care - The Construct

Like self-efficacy, self-care is a multidimensional construct, which encompasses several factors and which can take different forms for each individual, which means that its definition has several possible approaches. According to Posluns and Gall (2019), carrying out self-care practices means paying attention to one's own well-being in a holistic way, whether physical or emotional. The objectives of self-care practices are therefore related to “mitigating stress and promoting one’s own well-being”(Daly & Gardner, 2022), that is, not only in order to prevent negative consequences, but also to promote positive consequences in our lives.

To do this, it is necessary to be aware of the needs that the body and mind have, have a good social support system and have balance in each person's life (Posluns and Gall, 2019). Practicing self-care implies an intention to promote one's own health continuously over time, which requires self-reflection on the resources necessary for the person to satisfy their needs and, also, a consistent effort to maintain them (Colman et al. 2016; Rupert & Dorociak, 2019).

In practice, self-care can take many forms depending on “an individual’s personality, life situation, preferences, cultural context, gender or age” (Collins & Cassill, 2022). In this way, the concept is divided in the literature into several domains, Williams-Nickelson (2006) differentiates 6 domains of self-care: cognitive, physical, emotional, intellectual, social and spiritual. On a cognitive level we talk, for example, about managing expectations, on a physical level, physical exercise and a healthy diet (Daly & Gardener, 2022), on an emotional level we have the example of resorting to therapy, exploring ideas in a creative way on an intellectual level, going out with friends is considered social self-care and, finally, on a spiritual level we have examples such as participating in religious events or practicing rituals. These domains are characterized by their flexibility, and the specific activities of each may overlap (Posluns & Gall, 2019).

## The Self-Care of Psychologists

In addition to the areas discussed, there are self-care practices considered specific to psychologists. Here, we talk not only about self-care practices that maintain personal well-being, but also professional well-being. In developing the Self-Care Assessment for Psychologists Scale (SCAP), Dorociak and colleagues (2017) add questions related to the support received by co-workers and socialization with them, job satisfaction, monitoring feelings and reactions to certain clients, among other topics, maintaining the assessment of personal self-care.

The work of mental health professionals comes with unique demands (Rupert & Dorociak, 2019) and is, in itself, challenging work that puts psychologists at greater risk of distress (Posluns & Gall, 2019) and, eventually, burnout. (Tay et al., 2018). Tay and colleagues (2018) questioned 678 UK clinical psychologists about their mental health and seeking professional help. The results of the self-report questionnaires revealed that 62.7% of participants experienced one or more psychological problems at some point in their lives, with anxiety and depression being the most common. Of these participants, 84% sought help, either from their family doctor, psychologists or psychiatrists. However, the authors realized that stigma, shame and fear of a negative impact on their self-image results in a decrease in seeking help and reporting the problem, especially in the workplace.

Some authors mention reasons such as the number of cases that a psychologist has to follow (Bettney, 2017) and the emotional burden that these cases entail, such as monitoring patients who are unstable, aggressive or with suicidal ideation in the most extreme cases (Barnett et al. al., 2007). However, in Di Benedetto and Swadling's (2014) study of 167 Australian psychologists, participants reported low levels of burnout relative to their clients, and high levels of personal burnout, which refutes the argument that one of psychologists' stressors is the number of customers, and/or their difficulties.

However, other possible explanations are presented. Imposing limits and balancing what the other's need for care is and what your own needs are as a professional, who is also human, is a difficult task for anyone whose work involves care (doctors, nurses, therapists, etc.) (Skovholt, Trotter-Mathison, 2016). During their training, these

professionals are taught to be focused on helping their clients and their well-being, consequently, psychologists may fall into the tendency to neglect their own well-being in favor of the well-being of others ( Barnett et al., 2007). Tay and colleagues (2018) also suggest that there is a culture in mental health professions that promotes the notion that, in order to help others, professionals themselves cannot have problems because this would mean adopting the role of the client, a role of weakness. , and overcome a barrier that should not be crossed.

Therefore, self-care has been studied as a mechanism to combat these possible negative consequences. Rupert and Dorociak (2019) analyzed 5 areas of self-care - professional support, professional development, life balance, cognitive awareness and daily balance - defined by Dorociak and colleagues (2017), in a sample of 422 psychologists from the United States. The authors used regression models in which each of these areas of self-care was tested as a moderator between perceived stress and burnout, and also between perceived stress and satisfaction with one's life. Most regressions point to the sense that self-care is limited in mitigating the negative effects of stress on well-being, with the exceptions of professional development and cognitive awareness, which the lower the levels, the greater the probability of burnout. However, high levels of self-care in all areas were able to predict lower perceived stress and, consequently, lower burnout and greater satisfaction with life. (Rupert and Dorociak, 2019). Specifically for psychology students, support in their work context and in their personal life and awareness of their cognitions (thoughts, feelings, triggers, needs, etc.) are the most used strategies and which have a positive relationship with increased their psychological well-being (Zahniser et al., 2017; Miller et al., 2023). In the study by Miller and colleagues (2023), the fact that students had a balanced life predicted that they would have more positive affect and, furthermore, that self-care practices could mitigate the negative effects of perceived stress on well-being. Additionally, there is also evidence of a significant and negative relationship between mindfulness and burnout in psychologists (Di Benedetto & Swadling 2014).

Therefore, we can conclude, with some certainty, that self-care has benefits for psychologists who practice it. Now, if we come to the conclusion that self-care makes the person better as a whole, their functioning and well-being, it will also contribute to better professional performance (Zahniser et al., 2017), at the same time bringing positive

consequences for the customer, who will be provided with better quality services, with greater availability and commitment.

In short, self-care practices can reduce the risk of burnout for psychologists and the resulting risks for their clients (Di Benedetto & Swadling 2014). Given this importance of self-care practices in mental health professionals, several regulatory bodies for the profession include them in their code of ethics (Posluns & Gall, 2019). For example, the American Psychological Association (2016), in its Principle of Beneficency and Non-Maleficency, states that the physical and mental health of therapists influences the care of their patients, by impacting the effectiveness of their work. Therefore, it is essential that clinical psychologists adhere to self-care practices in order to prevent and mitigate the negative consequences that this profession can sometimes bring.

### Personal Therapy for Psychologists

Therapy has proven to be a crucial aid in the treatment of mental disorders and in the personal development of those who use these services (Gaskell et al., 2022). In this way, it is also considered as one of the tools included in self-care practices (Miller et al., 2023), which promote balance, help clients gain insight, improve personal relationships, among many other essential aspects of overall well-being.

Directing the discussion towards the use of personal therapy by psychologists, this and the benefit or harm it can have in the exercise of the profession continues to be a debated topic today. A large number of therapists have or have had personal therapy, with psychoanalytic therapists having the highest adherence rate and therapists with a cognitive-behavioral orientation the lowest (Norcross & Guy, 2001). Most of the research carried out is qualitative and focuses on understanding the impacts that personal therapy has on psychologists' personal and professional life satisfaction (Grimmer, 2015), with no strong results from randomized experimental studies on the impact of this variable (Norcross & VandenBos, 2018). That said, the possible inference about the implications of personal therapy for psychologists themselves as professionals and their clients is mostly theoretical and speculative.

Several authors argue that personal therapy is essential for the professional success of psychologists (Bennett-Levy, 2019), due to the various positive experiences

described by many therapists in the research carried out (Gold & Hilsenroth, 2009; Li et al., 2022; Bento & Sousa, 2022). One of the only quasi-experimental studies on this topic attempted to understand the impact of psychologists' personal therapy on their therapeutic alliance with their clients (Gold & Hilsenroth, 2009). For this, a sample of 60 psychologists was used, of which 30 had personal therapy and 30 received only supervision/intervisison. The results showed that, from the client's point of view, there were no differences in the perceived therapeutic alliance, although from the therapists' point of view this difference was significant - psychologists with personal therapy were more confident in their ability to collaborate and help their clients. In agreement with these results, Li et al. (2022) also came to the conclusion that psychologists who had already had experience in personal therapy had a greater level of confidence in their professional abilities. The psychologists in the study by Bento and Sousa (2022) also describe the integration of a therapist model and the appreciation of demonstrations of humanity in therapy as important gains from their personal therapy, which they transposed into their own work and intervention as therapists.

Another interesting result of the study by Gold and Hilsenroth (2009) is that the therapy of clients whose psychologists had personal therapy lasted twice as long as the therapy of clients in the control group. The authors suggest that this result may be due to the better perception of collaboration and goal setting in therapy, which propagates the duration of therapy. Whether this is the reason or not, the question arises as to whether a longer duration of therapy is a positive or negative thing, taking into account that each case is specific and may require more or less time. (Gold & Hilsenroth, 2009).

However, other studies have demonstrated negative experiences from psychologists who attended therapy. Qualitative research by Avis (2011) reveals that the perception of psychologists in personal therapy is not only positive and can bring some challenges that also involve the exercise of their profession, such as the cost of the sessions and the emotional commitment necessary to be in therapy. Another example of not-so-positive results is the study by Noble and Rizq (2019), in which cognitive-behavioral therapists revealed that their personal therapy called into question their own identity as therapists, caused internal conflict and made them unable to return to clinical practice in the same way. That being said, the inclusion of personal therapy in self-care practices, more specifically for clinical psychologists, can be called into question,

resulting from the ambiguity of experiences described and the variance of results in the literature.

## **Annex B - Sociodemographic Questionnaire**

Género - F/M/Outro

Idade -

Estado civil - Solteiro/Casado ou União de facto/Viúvo/Divorciado ou Separado

Qual a Universidade em que tirou o curso de Psicologia? -

Qual a sua média final à saída do mestrado? -

Qual a sua orientação terapêutica? - Psicanalítica ou Dinâmica / Sistémica ou Familiar /  
Cognitivo-Comportamental / Existencial ou Fenomenológica / Integrativa ou Eclética /  
Outra

Tem formação em psicoterapia? - Sim / Não

Anos de experiência na prática clínica -

Em média, quantas horas dedica ao exercício da Psicologia Clínica por semana? -

Exerce apenas Psicologia Clínica, ou também trabalha com outras áreas da psicologia? -  
Apenas Psicologia Clínica / Também trabalho com outras áreas da Psicologia

Se respondeu que também trabalha com outras áreas da Psicologia, indique quais. -  
Psicologia Escolar/Educacional / Psicologia Organizacional e do Trabalho / Psicologia  
da Saúde / Psicologia Criminal/Forense / Psicologia Social / Psicologia do Desporto /  
Neuropsicologia / Psicologia Comunitária / Psicologia do Desenvolvimento / Outros

Neste momento, qual o vínculo de trabalho em que se encontra? - Recibos Verdes /  
Empresa Própria / Contrato de trabalho com termo / Contrato de trabalho sem termo

Rendimento anual - < 20.000 € / 20.000€ a 30.000€ / 30.000€ a 40.000€ / 40.000€ a  
50.000€ / > 50.000€

Tem supervisão neste momento? - Sim / Não

Tem intervisão neste momento? - Sim / Não

Está, neste momento, em terapia pessoal? - Sim / Não

Já teve terapia pessoal no passado? - Sim / Não

Se respondeu sim a alguma das duas perguntas anteriores, qual foi o tipo de terapia e quanto tempo durou? -

## **Annex C - Informed Consent**

Caro(a) Participante,

O presente estudo insere-se no âmbito da dissertação de Mestrado Integrado em Psicologia Clínica, realizado no Instituto Universitário de Ciências Psicológicas, Sociais e da Vida (ISPA), com o Professor Dr. David Neto como orientador da mesma. Tem como objetivo principal a avaliação da relação entre o autocuidado, a terapia pessoal e a perceção de autoeficácia em psicólogos clínicos.

O questionário demora aproximadamente 10 minutos a completar e os riscos ao participar são mínimos. Não existem benefícios diretos de participar neste estudo. Ainda assim, a participação ajuda os investigadores a entender melhor a relação entre o autocuidado, a terapia pessoal e o desenvolvimento da autoeficácia de psicólogos clínicos, o que pode ajudar a melhorar o treino dos mesmos.

Toda a informação partilhada será mantida em confidencialidade. Os dados serão reportados em forma de dados de grupo, não sendo nenhum participante identificado na partilha dos resultados e, apenas as pessoas envolvidas diretamente na investigação terão acesso aos dados. A participação no estudo é voluntária, podendo ser retirado o consentimento de participação a qualquer momento sem qualquer penalização.

Para esclarecimento de qualquer dúvida, por favor contacte: Inês Gomes em [27289@alunos.ispa.pt](mailto:27289@alunos.ispa.pt)

Muito Obrigada!!

Concordo que li os termos de participação e aceito participar neste estudo –

## Annex D – Outputs of ANOVAS’ homogeneity of variance tests

Marital status:

### Testes de homogeneidade de variâncias

		Estadística de Levene	df1	df2	Sig.
Score total CASES (entre 0 e 369)	Com base em média	,225	2	204	,799
	Com base em mediana	,195	2	204	,823
	Com base em mediana e com gl ajustado	,195	2	201,599	,823
	Com base em média aparada	,196	2	204	,822

### Testes de homogeneidade de variâncias

		Estadística de Levene	df1	df2	Sig.
Score do fator Apoio Profissional (entre 5 e 35)	Com base em média	2,466	2	204	,087
	Com base em mediana	2,326	2	204	,100
	Com base em mediana e com gl ajustado	2,326	2	183,328	,101
	Com base em média aparada	2,386	2	204	,095
Score do fator Desenvolvimento Profissional (entre 5 e 35)	Com base em média	2,296	2	204	,103
	Com base em mediana	2,493	2	204	,085
	Com base em mediana e com gl ajustado	2,493	2	201,632	,085
	Com base em média aparada	2,286	2	204	,104
Score do fator Equilíbrio de Vida (entre 4 e 28)	Com base em média	1,170	2	204	,312
	Com base em mediana	,674	2	204	,511
	Com base em mediana e com gl ajustado	,674	2	184,833	,511
	Com base em média aparada	,945	2	204	,390
Score do fator Estratégias Cognitivas (entre 4 e 28)	Com base em média	2,866	2	204	,059
	Com base em mediana	2,604	2	204	,076
	Com base em mediana e com gl ajustado	2,604	2	192,683	,077
	Com base em média aparada	2,841	2	204	,061
Score do fator Equilíbrio Diário (entre 3 e 21)	Com base em média	,962	2	204	,384
	Com base em mediana	1,268	2	204	,283
	Com base em mediana e com gl ajustado	1,268	2	203,603	,283
	Com base em média aparada	1,080	2	204	,342

Therapeutic Orientation:

### Testes de homogeneidade de variâncias

		Estatística de Levene	df1	df2	Sig.
Score total CASES (entre 0 e 369)	Com base em média	,915	5	201	,472
	Com base em mediana	,893	5	201	,487
	Com base em mediana e com gl ajustado	,893	5	190,405	,487
	Com base em média aparada	,896	5	201	,485

### Testes de homogeneidade de variâncias

		Estatística de Levene	df1	df2	Sig.
Score do fator Apoio Profissional (entre 5 e 35)	Com base em média	1,327	5	201	,254
	Com base em mediana	1,138	5	201	,342
	Com base em mediana e com gl ajustado	1,138	5	186,323	,342
	Com base em média aparada	1,273	5	201	,277
Score do fator Desenvolvimento Profissional (entre 5 e 35)	Com base em média	1,283	5	201	,273
	Com base em mediana	,941	5	201	,456
	Com base em mediana e com gl ajustado	,941	5	193,344	,456
	Com base em média aparada	1,207	5	201	,307
Score do fator Equilíbrio de Vida (entre 4 e 28)	Com base em média	1,397	5	201	,227
	Com base em mediana	,951	5	201	,449
	Com base em mediana e com gl ajustado	,951	5	173,244	,450
	Com base em média aparada	1,398	5	201	,226
Score do fator Estratégias Cognitivas (entre 4 e 28)	Com base em média	1,274	5	201	,277
	Com base em mediana	1,199	5	201	,311
	Com base em mediana e com gl ajustado	1,199	5	188,362	,311
	Com base em média aparada	1,295	5	201	,267

Employment Status:

### Testes de homogeneidade de variâncias

		Estatística de Levene	df1	df2	Sig.
Score total CASES (entre 0 e 369)	Com base em média	,585	4	202	,674
	Com base em mediana	,540	4	202	,707
	Com base em mediana e com gl ajustado	,540	4	195,094	,707
	Com base em média aparada	,556	4	202	,695

### Testes de homogeneidade de variâncias

		Estatística de Levene	df1	df2	Sig.
Score do fator Apoio Profissional (entre 5 e 35)	Com base em média	,166	4	202	,955
	Com base em mediana	,129	4	202	,972
	Com base em mediana e com gl ajustado	,129	4	194,473	,972
	Com base em média aparada	,131	4	202	,971
Score do fator Desenvolvimento Profissional (entre 5 e 35)	Com base em média	3,707	4	202	,006
	Com base em mediana	3,145	4	202	,015
	Com base em mediana e com gl ajustado	3,145	4	185,436	,016
	Com base em média aparada	3,571	4	202	,008
Score do fator Equilíbrio de Vida (entre 4 e 28)	Com base em média	1,264	4	202	,286
	Com base em mediana	,580	4	202	,677
	Com base em mediana e com gl ajustado	,580	4	170,532	,677
	Com base em média aparada	1,092	4	202	,362
Score do fator Estratégias Cognitivas (entre 4 e 28)	Com base em média	,353	4	202	,842
	Com base em mediana	,515	4	202	,725
	Com base em mediana e com gl ajustado	,515	4	198,240	,725
	Com base em média aparada	,373	4	202	,828
Score do fator Equilíbrio Diário (entre 3 e 21)	Com base em média	1,634	4	202	,167
	Com base em mediana	1,588	4	202	,179
	Com base em mediana e com gl ajustado	1,588	4	193,379	,179
	Com base em média aparada	1,640	4	202	,166

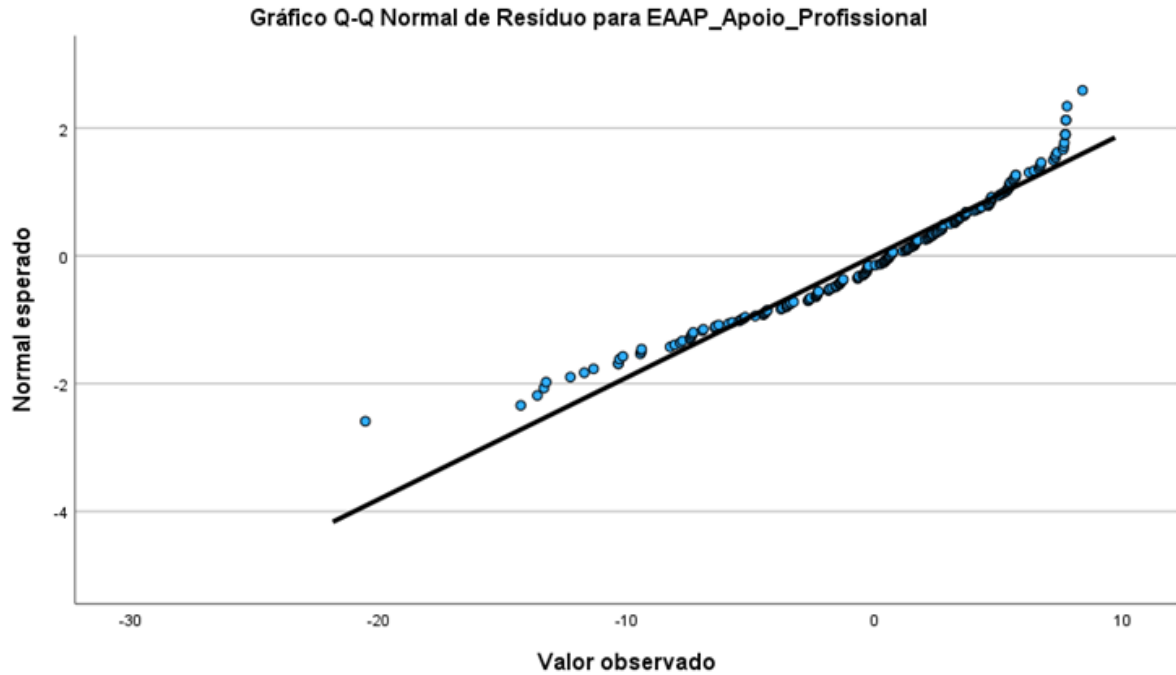
Personal Therapy:

### Testes de homogeneidade de variâncias

		Estatística de Levene	df1	df2	Sig.
Score do fator Equilíbrio de Vida (entre 4 e 28)	Com base em média	,929	3	203	,428
	Com base em mediana	,609	3	203	,610
	Com base em mediana e com gl ajustado	,609	3	183,629	,610
	Com base em média aparada	,832	3	203	,478

## Annex E – Outputs of ANCOVA assumptions – Marital status and Professional Support

Normal distribution of residuals:



Homogeneity of variances (p-value greater than .05):

### Teste de igualdade de variâncias do erro de Levene<sup>a</sup>

Variável dependente: Score do fator Apoio Profiss

Z	df1	df2	Sig.
2,438	2	204	,090

Testa a hipótese nula de que a variância do erro da variável dependente é igual entre grupos.

a. Design: Intercepto + Idade + Estado\_Civil

Homogeneity of regression coefficients (there should be no interaction between the covariate and the independent factor):

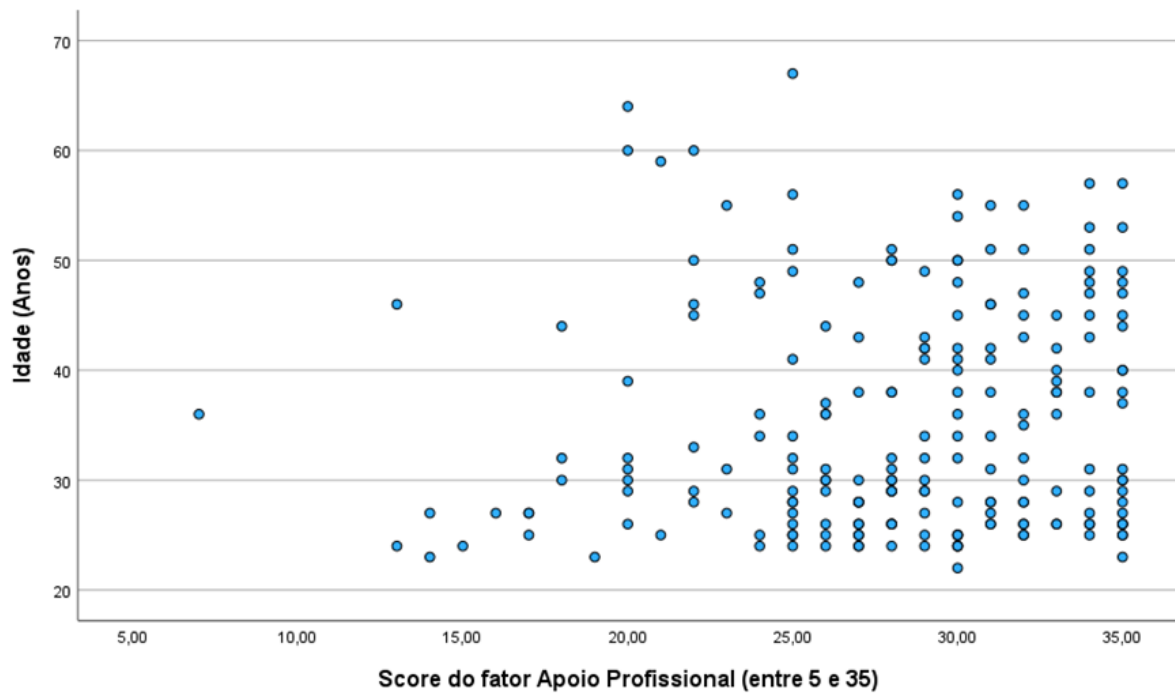
### Testes de efeitos entre sujeitos

Variável dependente: Score do fator Apoio Profissional (entre 5 e 35)

Origem	Tipo III Soma dos Quadrados	df	Quadrado Médio	Z	Sig.
Modelo corrigido	317,482 <sup>a</sup>	5	63,496	2,267	,049
Intercepto	2088,153	1	2088,153	74,566	<,001
Estado_Civil * Idade	33,411	2	16,706	,597	,552
Estado_Civil	67,573	2	33,787	1,206	,301
Idade	,289	1	,289	,010	,919
Padrão	5628,788	201	28,004		
Total	170482,000	207			
Total corrigido	5946,271	206			

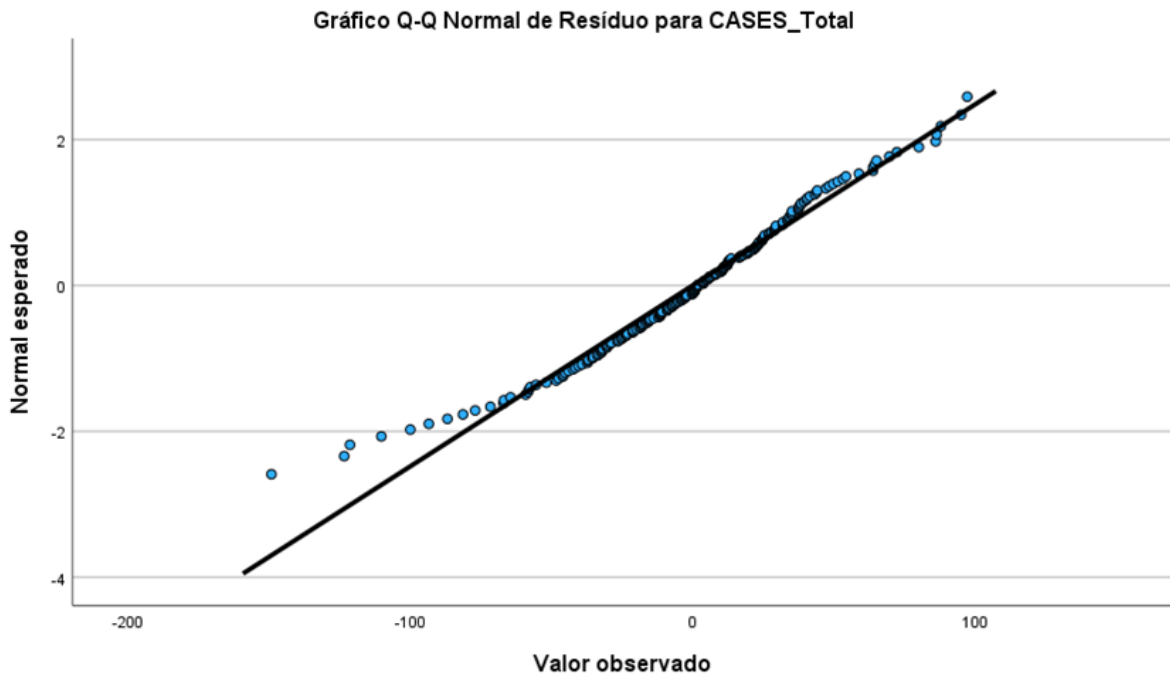
a. R Quadrado = ,053 (R Quadrado Ajustado = ,030)

Linearity between the dependent variable and the covariate:



## Annex F – Outputs of ANCOVA assumptions – Employment Satus and Self-Efficacy

Normal distribution of residuals:



Homogeneity of variances (p-value greater than 0.05):

### Teste de igualdade de variâncias do erro de Levene<sup>a</sup>

Variável dependente: Score total CASES (entre 0

Z	df1	df2	Sig.
,869	4	202	,483

Testa a hipótese nula de que a variância do erro da variável dependente é igual entre grupos.

a. Design: Intercepto + Idade + Vínculo\_Trabalho

Homogeneity of regression coefficients (there should be no interaction between the covariate and the independent factor):

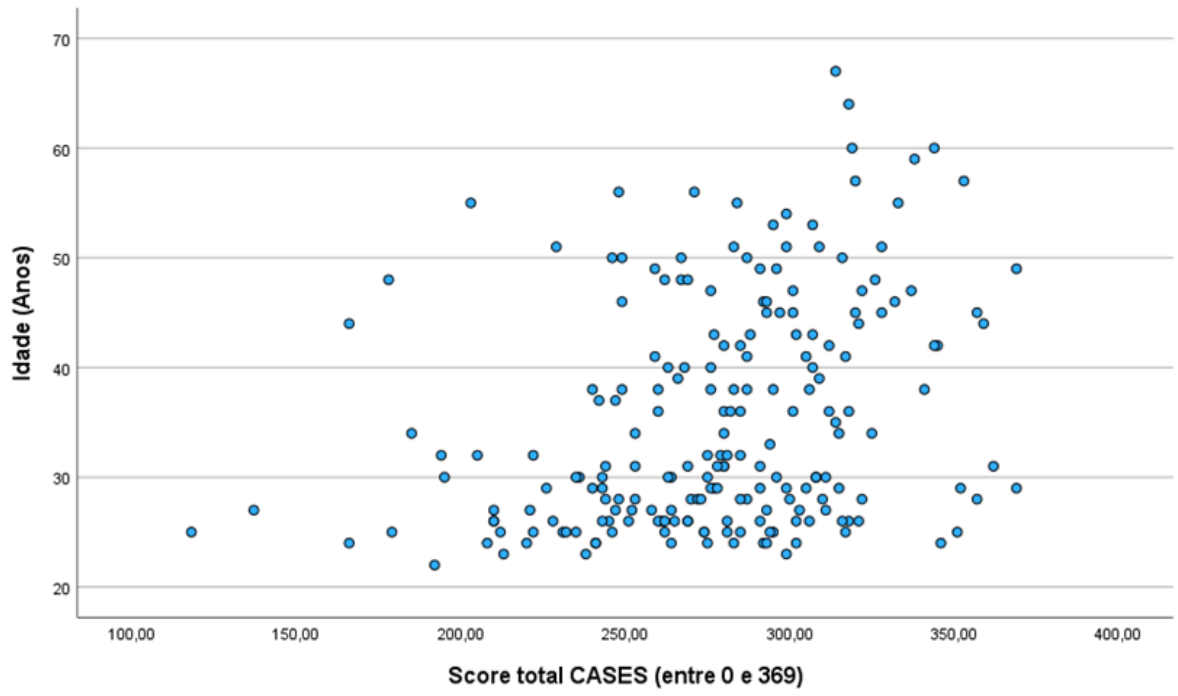
### Testes de efeitos entre sujeitos

Variável dependente: Score total CASES (entre 0 e 369)

Origem	Tipo III Soma dos Quadrados	df	Quadrado Médio	Z	Sig.
Modelo corrigido	47605,387 <sup>a</sup>	9	5289,487	3,136	,001
Intercepto	293757,586	1	293757,586	174,139	<,001
Vínculo_Trabalho	854,482	4	213,621	,127	,973
Idade	11055,328	1	11055,328	6,554	,011
Vínculo_Trabalho * Idade	1687,846	4	421,962	,250	,909
Padrão	332321,482	197	1686,911		
Total	16327714,000	207			
Total corrigido	379926,870	206			

a. R Quadrado = ,125 (R Quadrado Ajustado = ,085)

Linearity between the dependent variable and the covariate:



## Annex G - Outputs of Multiple Linear Regression – Model 1

### Resumo do modelo<sup>b</sup>

Modelo	R	R quadrado	R quadrado ajustado	Erro padrão da estimativa	Durbin-Watson
1	,532 <sup>a</sup>	,283	,265	36,80709	1,713

a. Preditores: (Constante), Score do fator Apoio Profissional (entre 5 e 35), Score do fator Equilíbrio Diário (entre 3 e 21), Score do fator Estratégias Cognitivas (entre 4 e 28), Score do fator Equilíbrio de Vida (entre 4 e 28), Score do fator Desenvolvimento Profissional (entre 5 e 35)

b. Variável Dependente: Score total CASES (entre 0 e 369)

### ANOVA<sup>a</sup>

Modelo		Soma dos Quadrados	df	Quadrado Médio	Z	Sig.
1	Regressão	107619,794	5	21523,959	15,888	<,001 <sup>b</sup>
	Resíduo	272307,075	201	1354,762		
	Total	379926,870	206			

a. Variável Dependente: Score total CASES (entre 0 e 369)

b. Preditores: (Constante), Score do fator Apoio Profissional (entre 5 e 35), Score do fator Equilíbrio Diário (entre 3 e 21), Score do fator Estratégias Cognitivas (entre 4 e 28), Score do fator Equilíbrio de Vida (entre 4 e 28), Score do fator Desenvolvimento Profissional (entre 5 e 35)

### Coeficientes<sup>a</sup>

Modelo		Coeficientes não padronizados		Coeficientes padronizados	t	Sig.	Estatísticas de colinearidade	
		B	Erro Erro	Beta			Tolerância	VIF
1	(Constante)	42,263	27,622		1,530	,128		
	Score do fator Apoio Profissional (entre 5 e 35)	-,058	,595	-,007	-,097	,922	,643	1,555
	Score do fator Desenvolvimento Profissional (entre 5 e 35)	1,805	,662	,206	2,726	,007	,625	1,601
	Score do fator Equilíbrio de Vida (entre 4 e 28)	1,029	,994	,077	1,035	,302	,649	1,540
	Score do fator Estratégias Cognitivas (entre 4 e 28)	6,678	1,185	,388	5,635	<,001	,752	1,331
	Score do fator Equilíbrio Diário (entre 3 e 21)	-,357	,680	-,033	-,524	,601	,876	1,142

a. Variável Dependente: Score total CASES (entre 0 e 369)

### Estatísticas de resíduos<sup>a</sup>

	Mínimo	Máximo	Média	Erro Desvio	N
Valor previsto	182,9901	317,7887	277,5652	22,85664	207
Resíduo	-143,83659	78,43179	,00000	36,35765	207
Erro Valor previsto	-4,138	1,760	,000	1,000	207
Erro Resíduo	-3,908	2,131	,000	,988	207

a. Variável Dependente: Score total CASES (entre 0 e 369)

Gráfico P-P Normal de Regressão Resíduos padronizados

Variável Dependente: Score total CASES (entre 0 e 369)

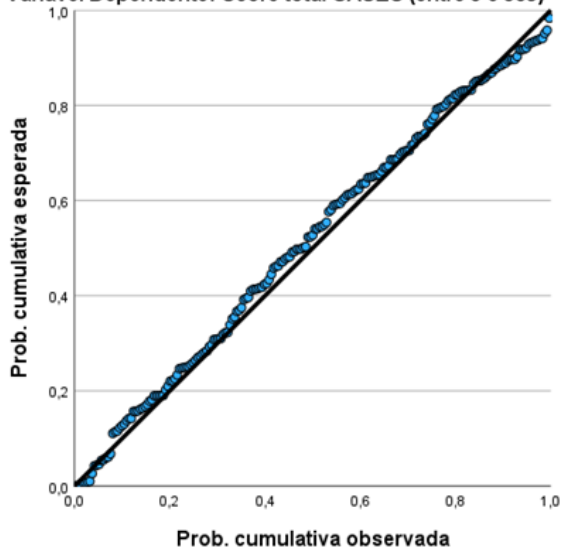


Gráfico de dispersão

Variável Dependente: Score total CASES (entre 0 e 369)

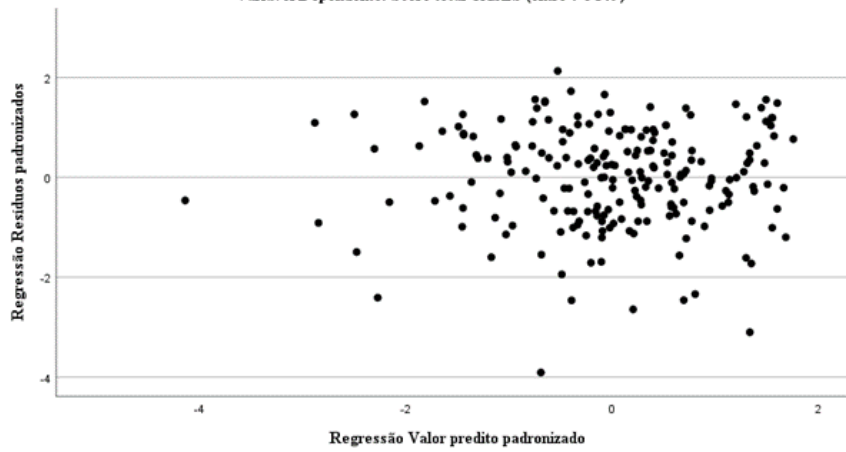


Gráfico de dispersão

Variável Dependente: Score total CASES (entre 0 e 369)



## Annex H – Results and Outputs of Multiple Linear Regression - Model 2

Model 2 inserted only the significant self-care subscales: Cognitive Strategies ( $\beta = .405$ ,  $t(200) = 6.605$ ,  $p < .001$ ) and Professional Development ( $\beta = .177$ ,  $t(200) = 2.846$ ,  $p = .005$ ); and also the age variable ( $\beta = .253$ ,  $t(200) = 4.343$ ,  $p < .001$ ). The adjusted R-squared increased by .097 when age and professional development were added to the cognitive strategies factor, showing a better fit of the model when the two new variables were included. However, this model, despite being statistically significant ( $F(3,200) = 34.805$ ,  $p < .001$ ,  $R_a^2 = .333$ ), did not show a major improvement in quality. Thus, Model 2 explains 33.3% of the variance in self-efficacy, increasing the explanatory power by 6.8% compared to Model 1.

**Resumo do modelo<sup>d</sup>**

Modelo	R	R quadrado	R quadrado ajustado	Erro padrão da estimativa	Durbin-Watson
1	,489 <sup>a</sup>	,240	,236	37,64065	
2	,562 <sup>b</sup>	,316	,310	35,77720	
3	,586 <sup>c</sup>	,343	,333	35,16161	1,661

a. Preditores: (Constante), Score do fator Estratégias Cognitivas (entre 4 e 28)

b. Preditores: (Constante), Score do fator Estratégias Cognitivas (entre 4 e 28), Idade (Anos)

c. Preditores: (Constante), Score do fator Estratégias Cognitivas (entre 4 e 28), Idade (Anos), Score do fator Desenvolvimento Profissional (entre 5 e 35)

d. Variável Dependente: Score total CASES (entre 0 e 369)

**ANOVA<sup>a</sup>**

Modelo		Soma dos Quadrados	df	Quadrado Médio	Z	Sig.
1	Regressão	90162,857	1	90162,857	63,638	<,001 <sup>b</sup>
	Resíduo	286197,320	202	1416,818		
	Total	376360,176	203			
2	Regressão	119078,517	2	59539,258	46,515	<,001 <sup>c</sup>
	Resíduo	257281,660	201	1280,008		
	Total	376360,176	203			
3	Regressão	129092,426	3	43030,809	34,805	<,001 <sup>d</sup>
	Resíduo	247267,750	200	1236,339		
	Total	376360,176	203			

a. Variável Dependente: Score total CASES (entre 0 e 369)

b. Preditores: (Constante), Score do fator Estratégias Cognitivas (entre 4 e 28)

c. Preditores: (Constante), Score do fator Estratégias Cognitivas (entre 4 e 28), Idade (Anos)

d. Preditores: (Constante), Score do fator Estratégias Cognitivas (entre 4 e 28), Idade (Anos), Score do fator Desenvolvimento Profissional (entre 5 e 35)

### Coeficientes<sup>a</sup>

Modelo		Coeficientes não padronizados		Coeficientes padronizados	t	Sig.	Estatísticas de colinearidade	
		B	Erro	Beta			Tolerância	VIF
1	(Constante)	69,323	26,244		2,642	,009		
	Score do fator Estratégias Cognitivas (entre 4 e 28)	8,404	1,054	,489	7,977	<,001	1,000	1,000
2	(Constante)	38,192	25,790		1,481	,140		
	Score do fator Estratégias Cognitivas (entre 4 e 28)	7,999	1,005	,466	7,959	<,001	,993	1,007
	Idade (Anos)	1,160	,244	,278	4,753	<,001	,993	1,007
3	(Constante)	23,948	25,836		,927	,355		
	Score do fator Estratégias Cognitivas (entre 4 e 28)	6,957	1,053	,405	6,605	<,001	,873	1,146
	Idade (Anos)	1,054	,243	,253	4,343	<,001	,969	1,031
	Score do fator Desenvolvimento Profissional (entre 5 e 35)	1,548	,544	,177	2,846	,005	,853	1,172

a. Variável Dependente: Score total CASES (entre 0 e 369)

### Estatísticas de resíduos<sup>a</sup>

	Mínimo	Máximo	Média	Erro Desvio	N
Valor previsto	200,2085	332,9963	277,3688	25,12484	207
Erro Valor previsto	-3,070	2,196	-,010	,996	207
Erro padrão do valor previsto	2,706	11,142	4,720	1,389	207
Valor previsto ajustado	204,0266	332,2808	277,3303	25,11018	207
Resíduo	-134,86653	65,51434	,19641	34,91526	207
Erro Resíduo	-3,836	1,863	,006	,993	207
Resíduos Resíduo	-3,863	1,884	,006	1,003	207
de Estud.	-136,81010	66,96273	,23491	35,65141	207
Resíduos de Estud.	-4,006	1,896	,004	1,011	207
Mahal. Distância	,207	19,387	2,978	2,625	207
Distância de Cook	,000	,070	,005	,010	207
Valor de ponto alavanca centralizado	,001	,096	,015	,013	207

a. Variável Dependente: Score total CASES (entre 0 e 369)

### Gráfico P-P Normal de Regressão Resíduos padronizados

Variável Dependente: Score total CASES (entre 0 e 369)

