Professional depression, ‘burnout’ and personality in longstay nursing

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Abstract—Conceptualizations of ‘burnout’ vary between authors. Some descriptions of burnout show strong similarities to depression in the work setting, or ‘professional depression’ as described by Oswin [Children Living in Long Stay Hospitals, 1978. Heinemann, London]. This study supported such a similarity, and demonstrated a considerable extent of depressed mood amongst nursing staff in longstay settings, which was particularly significant amongst male staff. A number of distinct ‘burnout’ responses were evident amongst staff including not only ‘professional depression’ and depersonalization but also the avoidance of problems and decisions. Ambiguity about supervisors’ expectations and success in meeting such expectations were associated with increased scores on each of these variables. Personality appeared to be related to staff’s responses. Staff prone to direct hostility inwards on themselves were more likely to show an avoidance of problems and decisions. Those staff prone to direct hostility outwards were more likely to report an awareness of depersonalization toward others. Both these processes may in different ways affect patient care and relationships with other professionals.

Introduction

Nursing is a stressful occupation. A particularly useful review of stress amongst nurses has been written by Marshall (1980). She emphasises that nursing can be stressful on two counts: because competence as a skilled worker is constantly on trial; and because of
constant awareness of vulnerability as a human being to the disabilities the nurse is caring for. Different kinds of nursing may also impose particular additional stresses. For example, Parkes (1980, 1982) has shown how medical and surgical nursing may differ in the discretion required and the support available, and how these factors are related to anxiety and depression.

These stresses have consequences for the nurse. Individuals may adopt coping strategies. They may also suffer strain. Cherniss (1980a, b) has written two particularly good discussions of these processes. Many others have also written about 'burnout' (e.g. Maslach, 1982; McConnell, 1982; McElroy, 1982), a term describing some of these strains, which has been given a variety of meanings. Cherniss has defined burnout as 'negative changes in work-related attitudes and behaviour in response to job stress'. This definition emphasises the extent of the strain some individuals experience in their response to the stresses of the job. One aim of this study was to explore the extent to which 'burnout' might resemble depression in work, or in work-related attitudes and behaviour.

Many writers have recorded the needs of nurses for support (e.g. Oswin, 1978; Redfern, 1981). But there has been little enquiry into what behaviour on the part of others is actually supportive, or what particular kinds of support are actually associated with lower levels of 'burnout', or of 'professional depression'. Marshall for instance has questioned whether nurses sharing their emotional responses is actually helpful, or not.

Experience from other fields suggests that action should be directed to reducing environmental pressures, and to supporting the role of the nurse in particular work situations. Marshall suggests that group meetings have only a limited potential for alleviating stress; this is probably true also of individual counselling approaches. Prevention is likely to be better than cure, and consequently more thought may need to be given to defining and supporting what nurses might be expected to accomplish in their jobs.

The kind of accomplishments which constitute success in long stay nursing are not always clear. In medical, psychiatric and mental handicap nursing, complete recovery is often not achievable. Frequently, the goals to be achieved may be seen in terms of amelioration of a disability, lessening of handicap, improvement in quality of life. In the past, such goals have often not been clearly articulated, and much longstay nursing used to have very broadly defined aims. The introduction of the nursing process is changing this. Specifying goals on paper will not, however, necessarily provide staff with a sense of accomplishment unless those goals are achievable and are consistent with wider service realities. What such nurses should be seeking to achieve in the course of day-to-day work needs extensive discussion, not merely written objectives.

This study was an attempt to explore a number of issues in this context. It takes further some earlier pilot studies which were reported by Firth and McIntee (1984).

Are 'professional depression' and some aspects of 'burnout' similar?

The first question is whether 'burnout' might have analogies with depression. Does the concept of 'professional depression', developed by Oswin (1978) in her study of mental handicap nursing, provide a useful framework for thinking about 'burnout'? Both Oswin's description of professional depression and Cherniss's (1980a, b) description of burnout—with broad motivational, perceptual, emotional and behavioural changes—show strong similarities to depression in other settings. This study therefore sought to compare an assessment of 'professional depression' in the work setting with Maslach and Jackson's description (1981a, b) of emotional exhaustion as a major component of burnout.


What other responses are manifested to these stresses?
Maslach and Jackson (1981a, b) have postulated three components to ‘burnout’: emotional exhaustion, lack of personal accomplishment and depersonalization. It was hypothesized that in longstay nursing, other separate responses to stress might be evident, such as the increasing rigidity described by Menzies (1960) and by Raynes et al. (1979).

How widespread is emotional exhaustion and depressed mood in longstay nursing?
This was an issue on which it was intended to gather some basic data for this particular sample.

Is personality related to individuals’ response to stress?
It might be expected that personality would affect individuals’ response to stress. Specifically, the tendency to direct hostility outward to others—or inward to oneself—appears a key aspect of personality in this context: anger is a well recognized component of depression, and often described as one aspect of ‘burnout’. It was predicted that those who often direct hostility at themselves would be more likely to experience professional depression, and staff prone to direct hostility outwards would be likely to experience one particular aspect of burnout, depersonalization.

Is role clarity associated with reduced ‘professional depression’ and emotional exhaustion?
Both Marshall and Cherniss’ work suggests that organizational supports might be important in the incidence of various kinds of ‘burnout’. Clarity of the nurses’ role appears from Raynes et al. (1979) to be important, so it was hypothesised that role ambiguity would be associated with higher levels of emotional exhaustion, lack of personal accomplishment and ‘professional depression’.

Method
An approach was made to all qualified nursing staff from three large psychiatric and mental handicap hospitals and the medical units of three general hospitals in one health district. 502 staff were asked to participate, 229 agreed and 200 questionnaires were returned. This represents a disappointing return rate, but was unsurprising given that staff were also asked to complete a questionnaire assessing the personal support received from their superior as part of another aspect of the study. (Questionnaires were confidential, but were identified by a code number.) There were no differences between staff who did or did not take part in the study in terms of age or length of experience.

Staff sampled included 63 enrolled nurses, 60 staff nurses, 62 charge nurses and 15 nursing officers. The age range for all grades included staff from their twenties to staff in their fifties and sixties. Average ages ranged from 29.3 yr for staff nurses, to 36.2 yr for charge nurses and 35.7 yr for enrolled nurses, and 45.6 yr for nursing officers. Experience in their grade ranged from 1.7 yr for staff nurses, 3.5 yr for charge nurses and enrolled nurses, to 8.3 yr for the nursing officers.

As ‘dependant’ variables, the questionnaire included the Maslach Burnout Inventory (Maslach and Jackson, 1981a, b) which assesses personal accomplishment, emotional exhaustion, and depersonalization toward patients, the Beck Depression Inventory (Beck and Beck, 1972), developed as a screening technique for depression in general practice, together with other questions devised to assess Oswin’s concept of ‘professional depression’ including
questions adapted from the Beck inventory. As 'independant' variables, the extent staff are prone to project hostility either inwardly on themselves or outwardly on others was assessed by the Bedford and Foulds (1978) Direction of hostility scales.

The degree of role clarity staff experience was assessed using four questions (Kahn et al., 1964).

— Does your immediate superior usually let you know when they expect or want something from you or do they often keep these things to themselves?
— Do you usually feel that you know how satisfied s/he is with what you do?
— How clear are you about what you have to do in this job?
— How clear are you about the limits of your authority in your present position/job?

Results

Are 'professional depression' and some aspects of 'burnout' similar?

Table 1 sets out results suggesting much similarity between 'emotional exhaustion' and 'professional depression'. A factor analysis on 'dependant' variable items was used to cluster questionnaire items correlating highly with each other. Principal factoring with varimax rotation of extracted factors to an orthogonal simple structure solution (Child, 1970; Nunnally, 1978) was employed using a program published under the Statistical Package for the Social Services (Nie et al., 1975). Although such techniques do not yield one 'correct' solution, this analysis clustered together, in the first factor, 19 items to do with feelings of frustration, exhaustion and discouragement about work. There was considerable overlap between the professional depression items and the 'Emotional exhaustion' items from the Maslach Burnout Inventory. The two scales correlated highly (Pearson $r = 0.59$, $P < 0.001$) and four of the Emotional exhaustion items were included in this cluster. These results are listed in Table 1. This first factor included statements of reduced motivation, lowered mood, changes in the perception of self and others (e.g. I feel worthless/I am less interested in patients) and likely behavioural changes (I get tired at work). This wide variety of associated changes in a number of areas of functioning, which some staff experienced, does indeed suggest an analogy with depression, and the results indicate an overlap between 'professional depression' and the 'Emotional exhaustion' dimension of burnout.

What other responses are manifested to these stresses?

The study did also distinguish other experiences. The factor analysis highlighted five separate experiences the nurses reported (see Table 1).

Professional depression. This represents generalized changes in mood, motivation, perception and very likely in behaviour in the work setting.

Lack of personal accomplishment. Maslach and Jackson (1981a, b) have identified the presence or absence of personal accomplishment as a central feature of 'burnout' syndromes, and this analysis confirmed that. Accomplishment here describes the sense that one is positively influencing others' lives and achieving worthwhile outcomes in one's job.

Avoidance of decisions, problems or changes in work. Some staff reported that they respond to work stresses by trying to avoid all of these potentially threatening events. This response was correlated with reports of low levels of personal accomplishment (Pearson $r = 0.37$, $P < 0.001$).

Emotional draining. Separate from these experiences, a cluster of items from the MBI described being 'drained' by work. (This result is reported in more detail by Firth et al., 1985.)
### Table 1. Item factor loadings

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<td>56</td>
<td>05</td>
<td>40</td>
<td>03</td>
<td>19</td>
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</table>

(1) Professional depression

1. I get discouraged at work
2. My enthusiasm for my work has dwindled
3. Sometimes I feel I am in a bit of a rut at work
4. My appetite for my present job is not as good as it used to be*
5. I feel a little depressed in my work*
6. I am sad or unhappy about my work*
7. I feel discouraged about the future of my work*
8. I get tired at work more easily than I used to*
9. I feel worthless at work*
10. I am disappointed in myself in my work*
11. I feel dissatisfied with everything at work*
12. I am less interested in patients than I used to be*
13. I feel frustrated by my job?
14. I feel like I am at the end of my rope?
15. I feel somewhat disinterested at work
16. Sometimes I feel I am getting a little institutionalized
17. I long for my days off
18. I feel fatigued when I get up in the morning and have to face another day on the job†
19. I feel burned out from my work?

(2) Lack of personal accomplishment

20. I deal very effectively with the problems of my recipients†
21. I can easily create a relaxed atmosphere with my recipients†
22. In my work I deal with emotional problems very calmly†
23. I feel exhilarated after working closely with my recipients?
24. I have accomplished many worthwhile things in this job†
25. I feel I'm positively influencing other people's lives through my work†
26. I feel very energetic†

(3) Emotional draining

27. I feel emotionally drained from my work†
28. I feel used up at the end of the work day†
29. Working with people all day is really a strain for me†

(4) Avoidance of questions, decisions or changes

30. I try to put off making decisions at work
31. I often feel threatened when people at work ask me questions
32. I sometimes feel like dealing with problems by pretending they don't exist
33. I feel a little unsettled if my routine gets changed

(5) Awareness of hardening toward people

34. I worry that this job is hardening me emotionally†
35. I've become more callous toward people since I took this job†
36. I feel recipients blame me for some of their problems†

<table>
<thead>
<tr>
<th>Eigen value</th>
<th>11.52</th>
<th>4.02</th>
<th>2.29</th>
<th>1.90</th>
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<td>Per cent variance accounted</td>
<td>34.5%</td>
<td>12.0%</td>
<td>6.9%</td>
<td>5.7%</td>
<td>5.0%</td>
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<td>Decimal Points omitted</td>
<td></td>
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<td></td>
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</tbody>
</table>

*Items adapted from the Beck Depression Inventory to assess feeling of 'professional depression' about work.
†Items from the Maslach Burnout Inventory reproduced by special permission of the publisher, Consulting Psychologists Press, Inc. from the Human Services Survey by Christina Maslach and Susan Jackson, Copyright 1981. The word 'patients' was used instead of 'recipients' for this British nurse sample.
An awareness of ‘hardening’ towards others or ‘depersonalization’. These statements, also from the Maslach Burnout Inventory, describe an awareness of becoming ‘tough’ or adopting a depersonalized response to others: either patients or other staff.

The extent of the problem: how widespread is emotional exhaustion and depressed mood?

It is difficult to say how severe these experiences were amongst this sample of nurses because there is little in Britain against which to compare the results of this study. However, Table 2 lists the scores of this sample of British qualified nurses on the Maslach Burnout Inventory with those of a variety of public servants in the United States. Emotional exhaustion and depersonalization scores were significantly lower amongst these British nurses than in the United States sample (which did however include more social security staff than nurses).

Professional depression scores were significantly correlated with scores on the Beck Depression Inventory (Pearson \( r = 0.54, \ p < 0.001 \)). The incidence of depressed mood amongst these qualified nurses was quite considerable (Table 3). The data from this study have been compared with data from a recent but separate study of depressed mood amongst 360 adults in the general population (Firth, personal communication). Depressed mood is slightly commoner amongst the female nurses—although this difference could be due to chance; but it is strikingly and significantly more prevalent amongst male nurses than amongst men in the local population.

Is personality related to individuals’ response to stress?

Anger is a well recognized aspect of depression, sometimes directed outward (when depression may not be recognized), sometimes inward (as in thoughts of suicide). It was expected that those suffering ‘burnout’ who tend to direct anger inwardly would experience professional discouragement or ‘depression’, and those whose anger is outwardly directed might experience depersonalization or negative feelings toward patients or others. The result was not quite as expected.

Those whose anger tends to be toward others were indeed significantly more likely (Pearson \( r = 0.37, \ p < 0.001 \)) to report feelings of depersonalization or ‘hardening’ toward others in their work. But those who usually direct anger at themselves proved significantly more likely (Pearson \( r = 0.53, \ p < 0.001 \)) to report a burnout response including an avoidance of decisions or problems. It seems that where nurses suffer ‘burnout’, then personality may have an important influence on the type of ‘burnout’ response they develop.

Is role clarity associated with reduced professional depression and emotional exhaustion?

The degree of role ambiguity staff experienced had a strong and highly significant relationship to staffs’ professional depression scores, and to their reports of avoiding decisions, problems or changes (correlations, respectively, 0.42 and 0.37, \( P < 0.001 \)). Role ambiguity was also related to lack of personal accomplishment, emotional draining and depersonalization (Pearson \( r \), respectively, 0.25, 0.29, 0.28, \( P < 0.001 \)).

Conclusions

The results supported the hypothesis that emotional exhaustion as a ‘burnout’ response shows strong similarities to a ‘professional depression’ as described by Oswin (1978). However, ‘professional depression’ was found to be distinguishable from a number of
Table 2. Emotional exhaustion, depersonalization and personal accomplishment: means and standard deviations (Maslach Burnout Inventory Frequency Scores)

<table>
<thead>
<tr>
<th></th>
<th>Present sample</th>
<th>Maslach and Jackson's original sample (1981)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>British qualified nurses (N= 200)</td>
<td>U.S. nurses, teachers, civil servants (N= 1400)</td>
</tr>
<tr>
<td>Emotional exhaustion:</td>
<td>mean</td>
<td>18.3*</td>
</tr>
<tr>
<td></td>
<td>standard deviation</td>
<td>9.5*</td>
</tr>
<tr>
<td>Depersonalization:</td>
<td>mean</td>
<td>5.9</td>
</tr>
<tr>
<td></td>
<td>standard deviation</td>
<td>5.1</td>
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<tr>
<td>Personal accomplishment:</td>
<td>mean</td>
<td>35.9</td>
</tr>
<tr>
<td></td>
<td>standard deviation</td>
<td>7.3</td>
</tr>
</tbody>
</table>

*Emotional exhaustion and depersonalization scores are significantly lower for this sample of British nurses than in Maslach and Jackson’s (1981a, b) original standardization sample of staff in the United States (Student's t-test, t = 5.92 and 6.12, respectively, significant at P = <0.001).
<table>
<thead>
<tr>
<th></th>
<th>Nursing officers (N = 15)</th>
<th>Charge nurses (N = 61)</th>
<th>Staff nurses (N = 60)</th>
<th>Enrolled nurses (N = 61)</th>
<th>All nursing staff</th>
<th>Population sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Women (N = 140)</td>
<td>Women (N = 195)</td>
</tr>
<tr>
<td>Not depressed</td>
<td>13 (87%)</td>
<td>41 (67%)</td>
<td>43 (72%)</td>
<td>38 (62%)</td>
<td>99 (71%)</td>
<td>148 (76%)</td>
</tr>
<tr>
<td>Mildly depressed</td>
<td>2 (13%)</td>
<td>13 (21%)</td>
<td>12 (20%)</td>
<td>16 (26%)</td>
<td>31 (22%)</td>
<td>27 (14%)</td>
</tr>
<tr>
<td>Moderately depressed</td>
<td>—</td>
<td>6 (10%)</td>
<td>5 (8%)</td>
<td>7 (12%)</td>
<td>9 (6%)</td>
<td>19 (10%)</td>
</tr>
<tr>
<td>Severely depressed</td>
<td>—</td>
<td>1 (2%)</td>
<td>—</td>
<td>—</td>
<td>1 (0.7%)</td>
<td>1 (0.5%)</td>
</tr>
</tbody>
</table>

*Differences were significant between male nursing staff and men in the population sample (chi-square = 21.2, P<0.001) but differences were not significant for women. Data for general population from Firh and Chaplin (personal communication).*
different experiences reported by nursing staff, including avoidance of problems, 'depersonalization', emotional draining or lack of accomplishment.

Much has been made in the literature on burnout of 'depersonalization'—the consequences of stresses in work projected onto the consumers of services. Less interest has been shown in the insidious effects on patient care which may result from reluctance or resistance to change, and the avoidance of decisions or problems. This study has highlighted that this response to stress at work may be more likely amongst those who suffer a lack of personal accomplishment, and who tend to direct hostility inwards onto themselves. Depersonalization may be a risk primarily amongst those who under stress are habitually prone to direct hostility outwards onto others. There is not evidence here to comment on the possible causal nature of this connection.

Nevertheless these results may have particular significance in selecting and supporting staff whose work is likely to bring them particularly into contact with clients (for whom depersonalization should be particularly avoided) and on the other hand amongst staff whose work is likely to involve facing, planning for and meeting change with positive decisions (for whom coping with stress by avoidance would be particularly disastrous).

'Burnout' is a multi-faceted concept, whose frequent usage covers a variety of responses to the stresses of working with people. This study confirmed that a number of different and distinct responses to the stresses of work can be distinguished. Amongst these are lack of personal accomplishment, previously identified by Maslach and Jackson (1981a, b), depersonalization, and emotional draining or emotional exhaustion, also identified by those authors.

Additionally, this study identified a set of responses to problems, decisions or questions, characterised by avoidance; it seems likely that this represents a particular coping response to stress employed by those staff.

The overlap between the emotional exhaustion as described by Maslach and co-workers with the items in this study adapted to describe a professional 'depression' supports the usefulness of Cherniss' characterization of burnout—namely as a complex of motivational, affective, behavioural and perceptual or attitudinal changes. That such changes may have analogies with depression, and correlate with depressed mood, has been stressed previously (e.g. Meier 1983, 1984). How often and to what extent 'professional depression' may resemble clinical depression remains an open issue. However, the extent of both mild and moderate degrees of depressed mood amongst the male staff in this sample is disturbing and worthy of further attention. The rates amongst female staff are also of practical significance for nurse managers, even though not significantly different for rates found amongst women in the local population.

Role clarity probably does not derive from written procedures or job descriptions, but from face-to-face interaction with superiors, who convey in a variety of ways what is expected of staff, and how they are perceived to be performing. Perceived role clarity may well be influenced by the state of mind of the individual. Nevertheless, these results would suggest that a clear sense of direction, as well as clear expectations and feedback on what constitutes good work performance, are very necessary if staff are not to suffer professional depression.

Whether the responses to stress identified in this paper actually affect staffs’ interaction with their colleagues or with patients remains an open question, although Revans (1976) demonstrated a long while ago the dramatic correlation between staff morale and patients’ recovery rates. However, the results of another part of this study, into the nature of effective
support as perceived by nursing staff, strongly suggests that depersonalization, at least, does affect the support staff are able to offer other staff (Firth et al., 1986). Staff experiencing depersonalization were perceived by their subordinates as offering little personal respect. As clear expectations and feedback from a superior appear from the results here to affect the degree to which staff report depersonalization, it seems likely that feelings of depersonalization toward others and poor support may perpetuate each other downwards through a management structure. Attention to the selection and support of those in senior posts, to avoid professional depression, depersonalization and an avoidant coping style at these levels therefore seems particularly important.

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References


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