

Counsellors' Need of Social Support

Lars Glasø ^a

Tina Løkke Vie^b

Stig Berge Matthiesen^a

^a BI Norwegian Business School, Oslo, Norway

^b Førde Health Trust, Norway

ABSTRACT

The present study investigates the impact of social support on mental health among Norwegian counsellors. Data were collected by means of anonymous self-report questionnaires addressing central aspects of the counsellors' job, health and well-being. The results show that leader support act as a strong predictor of counsellors' mental health compared to other sources of social support, such as co-worker support, family support and friend support. Furthermore, the results indicate that leader support moderates and has a stress-preventing effect on the relationship between perceived stress and mental health. Thus, the findings suggest that leader support is an important factor likely to influence the health of counsellors.

Key Words: *Leadership, counsellors, social support, strain, mental health.*

Introduction

Theoretically, work-related health outcomes have been explained by the stressor-strain relationship (Beehr, 1995; Harris & Kackmar, 2005), where physical or psychosocial work characteristics are viewed as predictors to stress reactions and strains. Although stress reactions may serve an adaptive function e.g., “eustress” (Simmons & Nelson, 2001), considerable research has shown that certain job stressors can elicit physical and psychological stress responses which over time can result in physical and psychological strain, including cardiovascular disease, high blood pressure, anxiety and depression (Cartwright, 2010; Kaufmann & Beehr, 1986; Lazarus & Folkman, 1984; Simmons & Nelson, 2001).

One variable thought to influence individual strain reactions is social support (Ganstner, Fusilier & Mayes, 1986; Viswesvaran, Sanches & Fisher, 1999). Social support is defined as the availability of helping relationships and the quality of those relationships (Leavy, 1983). While the stress process involves a multitude of influential factors, including work environment and personal characteristics, the degree of social support that individuals receive has been recognized as a highly relevant “buffer” protecting individuals from the pathological consequences of stressful experiences (Cohen & Wills, 1985). From a social support perspective, leaders represent an important resource likely to influence their subordinates’ health, as leaders’ behaviour seems to play an important role regarding the degree to which a work setting is perceived as ‘supportive’ (House, 1981; Thanacoody, Bartram & Casimir, 2009).

Counsellors constitute a special work group. Using therapeutic techniques as their tools and the consultation room as their arena, their job is to provide care to others in need of support and guidance. But then the questions arise: Where do counsellors themselves find social support? Does it come from their superiors or elsewhere? The aim of the present study is to examine the role of social support as it is experienced by a nationally representative group of Norwegian psychologists. The importance of such support will be compared with other types of support from co-workers, family and friends. Mental health will comprise the outcome measure.

In Norway most psychologists work as counsellors or therapists. As such, they are daily confronted with intense emotions and the troublesome conflicts of other people, including suicide threats, aggressive hostility, psychotic behavior, and criminality (Deutsch, 1984). However, there

are also other aspects of the profession that may contribute to a counsellor's distress. According to Baker (2003), achievement, career development, an increased standard of living, upward mobility, status, and prestige all come at a price in terms of amount of work, pressure and health-related strain. Based on the nature of their work, counsellors represent an important group for study with regard to stress reduction. For example, a review of studies of UK clinical psychologists suggests that the majority find their work highly demanding, and up to 40% experience high levels of distress (Hannigan et al., 2004). In a qualitative study, Rønnestad and Skovholt (2003) interviewed 100 American counselors/therapists at different experience levels. Overall, as many as 1/3 of therapists reported stressful involvement with their clients (see also Orlinsky & Rønnestad, 2005). Accordingly, studies have shown that psychologists report health-related strains such as burnout (Ackerley, Burnell, Holder & Kardek, 1988; Farber, 1990; Guy, Poelstra & Stark, 1989; Rupert & Morgan, 2005), fatigue, irritability, disillusionment, self-doubt (Mahoney, 1997), exhaustion, depression and vicarious traumatization (Smith & Moss, 2009). Today, there is academic consensus that therapy and counselling is a major mediator of burnout for psychologists (Nissen-Lie, Monsen, Ulleberg & Rønnestad, 2013; Thériault & Gazzola, 2005).

Stressful work conditions may not only affect the counsellors themselves, but can also have negative effects on patient care, highlighting the need to identify important factors that can alleviate the potential strains experienced by this group of professionals (Smith & Moss, 2009). Yet, according to Rupert and Morgan (2005), research regarding counsellors has been too narrow and has consisted primarily of investigations of the stress of psychotherapeutic work as correlates of burnout. Research on other mental health variables is still limited, and research thus far basically has involved surveys that have included small samples of counsellors (Bears, McMinn, Seegobin & Free, 2013).

As outlined above, social support can be considered as a potential resource likely to influence individuals' strain reactions. More specifically, social support may take the form of emotional support - provision of empathy, love and caring; instrumental support - provision of material goods and services; informational support - provision of suggestions and advice; and appraisal support - provision of information that is helpful for self-evaluation purposes (House, 1981). Yet the types of social support have not always been clearly distinguished. Some researchers have

focused only on one type of support (e.g., Kickul & Posig, 2001), while others have combined separate measures of different types of social support into a single index, assuming that the various aspects of social support are highly interrelated, e.g., offering informational support often concurrently implies giving affective support, in addition to direct aid (Frese, 1999).

It has been common to distinguish between work-related and non-work-related sources of social support. Work-related sources of social support refer to social support from leaders and coworkers, whereas non-work-related sources refer to extra-organizational sources, such as spouse, family and friends (van Daalen, Sanders & Willemsen, 2005). According to Beehr (1985), work-related stress is most effectively managed by work-related sources of support, since the stress response occurs in the context of the stressful situation (see also Barling, Bluen & Fain, 1987; Viswesvaran, Sanches & Fisher, 1999). In this respect leaders hold a central position being salient persons in an individual's work context, and therefore are likely to exert a direct influence on subordinates' behavior (Kozlowski & Doherty, 1989; O'disroll & Beehr, 1994). Consistent with this view, the leadership literature provides ample evidence that subordinates are strongly influenced by leader behavior, regardless of whether that behavior is perceived as good or bad (Glasø, Skogstad, Notelaers & Einarsen, 2017).

Leader behavior such as consideration, support, and empowerment have been related to increased psychological well-being (Amundsen & Martinsen, 2014; Gottfredson & Aquinis, 2017; Ng, 2017), less perceived stress (Harris & Kackmar, 2006) and less burnout among employees (Huang, Chan, Lam, & Nan, 2010). Conversely, unsupportive leader behaviors such as abusive supervision (Tepper, 2000), Laissez faire leadership (Skogstad, Hetland, Glasø & Einarsen, 2014) and lack of interactional justice (Kelloway, Sivathan, Francis & Barling, 2004), have been related to high levels of stress and negative health outcomes. Yet some studies have shown that other non-work-related sources of support may be more effective than workplace support in alleviating the effects of work-related strain. For example, in a study of teachers, Greenglass, Fiksenbaum and Burke (1994) found that family support was more effective than workplace support in easing the effects of work stress on burnout. Moreover, in a study of 211 traffic enforcement agents, Baruch-Feldman et al., (2002) found that family support was more closely associated with burnout than with satisfaction or with productivity, whereas immediate supervisor support was related to satisfaction and productivity but not to burnout. Thus, despite abundant

evidence of the beneficial effects of social support in general, it is still unclear as to what extent social support from leaders influences subordinates' health, as compared to other sources of social support.

Further, it is unclear *how* social support from leaders may influence the health of employees. In the mainstream literature, different theoretical models of how social support affects the stressor-strain relationship have been suggested. According to Dormann and Zapf (1999), the majority of the social support studies investigate one of the following hypotheses: (1) *the direct (main) effect*, assuming that social support has a direct positive impact on health, e.g., the more support people receive, the less likely symptoms of mental or physical ill-health will appear, (2) *the moderating (interaction) effect* also known as the buffering effect, assuming that social support moderates the relationship between stressors and strains, i.e., social support works as a buffer and prevents stressors from developing their impact on strain, meaning that there is a strong stressor-strain relationship when support is low, and a weak or no stressor-strain relationship when support is high, (3) *the indirect (mediating) effect*, assuming that social support reduces the strength of the stressor and subsequently reduces the probability of ill-health, indicating that social support may have a stress-preventive effect by influencing the stress perception, which again will influence health, and thus act as a mediator between leader support and health outcomes.

The hypotheses presented above have been separately tested in several studies. For instance, research has found that leader support may have a direct effect on subordinates' health in terms of burnout (Graham & Witteloostuijn, 2010), affective and somatic outcomes (Ganster et al., 1986), whereas a study by Lee (2011) has provided evidence that leader support, in terms of leader-member-exchange (LMX) (Graen & Uhl-Bien, 1995; Gottfredson & Aquinis, 2017) may moderate the stressor-strain relationship. Furthermore, Thomas and Lankau (2009) found that supportive leader behavior minimizes emotional exhaustion through increased socialization and decreased role stress. On the other hand, Dormann and Zapf (1999) did not find any main effect of leader support on depression in a longitudinal study among Germany citizens, yet they did find a moderating effect. However, the picture is blurred, as there are also studies that do not support the notion of a moderator effect of leader support on mental health, only the existence of a main effect (e.g., Ganster et al., 1986).

The inconclusive findings regarding leader support processes may be due to different contexts, designs and operationalizations of the concepts of stress and support. In line with this, van der Doef and Maes (1999) argue for a more occupation-specific approach, suggesting that prior research regarding the stressor-strain relationship largely ignores the impact of the job situation itself. Using more job-specific measurements for occupational groups may enable a more specific understanding, and would accordingly lead to the development of more appropriate interventions in the workplace to improve employees' health (Collins, Hislop & Cartwright, 2016; Glasø, Bele, Nielsen, & Einarsen, 2011; Richardsen & Martinussen, 2007).

Based on these arguments, the purpose of the present study is to investigate the need of social support to a large sample of counsellors in Norway. One aim is to examine to what extent social support from leaders as compared to other sources of social support influences the counsellors' strain reactions in terms of mental health. Given the unique demands and professional challenges involved in a counsellor's work, and that stress coping occurs in the context of the stressful situation (Beehr, 1985), it seems plausible that work-related stress is effectively dealt with by work-related sources of support, and in particular social support from leaders. Although the job-autonomy of many counsellors seems to be high as they provide care on a one-to-one basis, many also work in team-based constellations, as well as in professional-based bureaucracies (e.g., hospitals and school systems), where the work is highly regulated and the leader may represent a difference with regard to their perceived stressors at work. Further, given the leaders' role in defining and influencing an environment in which employees can thrive and feel worthy (Skakon, Nielsen, Borg, & Guzman, 2010), we assume that leaders would be an important source of social support, and, according to the direct effect hypothesis (Dormann & Zapf, 1999) will have a direct influence on the mental health of counsellors. To empirically investigate this assumption, we will test the following hypothesis:

H1: Leader support will significantly improve the prediction of mental health among counsellors.

Further, on the basis of the theoretical models of *how* social support may affect the stressor-strain relationship (see Dormann & Zapf, 1999), we hypothesize that leadership support not only has a direct influence on health, but will also act as a moderator in the stressor-strain relationship. This leads to the next hypothesis:

H2: Leader support moderates the relationship between perceived stress and mental health among counsellors.

Finally, while H2 proposes that leader support intervenes after stress perception and exerts its effect by reducing the severity of the stress response, thus avoiding or moderating risks to health, we also hypothesize that leader support may indirectly influence the probability of ill-health through the mechanism of stress-perception. This means that leader support directly influences perceived stress and subsequently the probability of ill-health, meaning that social support has a stress-preventive effect. This will be tested in the following hypothesis:

H3: The relationship between leader support and counsellors' mental health is mediated by perceived stress.

The theoretical model that captures H1-H3 is presented in figure 1.

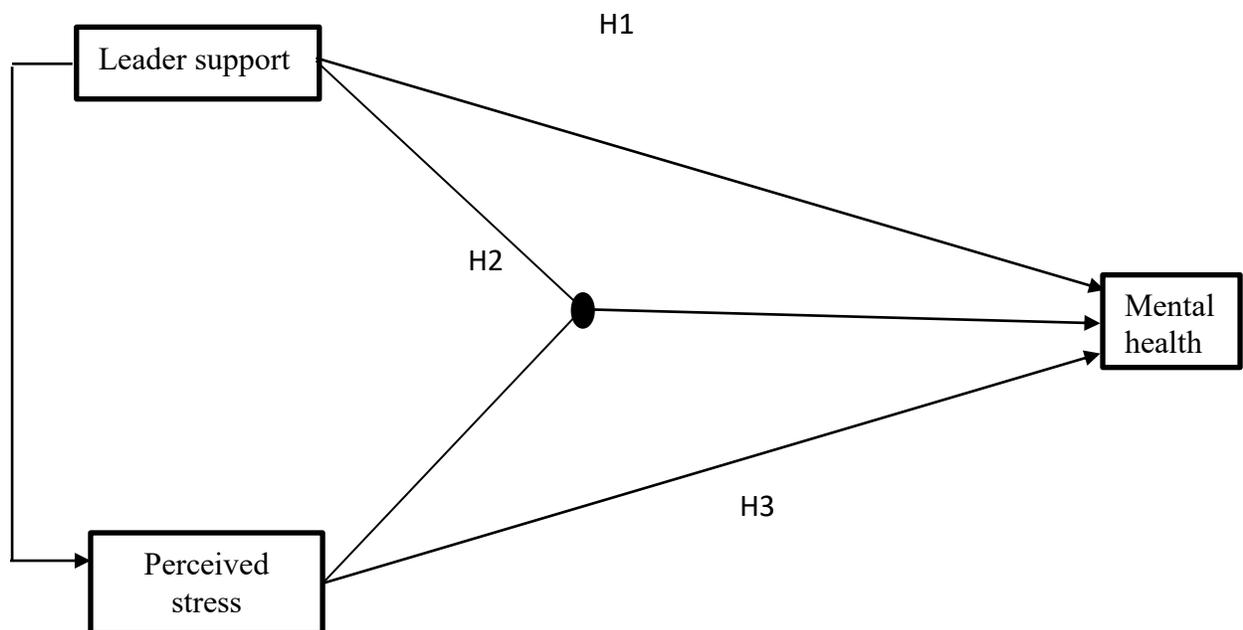


Figure 1: Theoretical model: The link between leader support, perceived stress and mental health among counsellors.

Method

Sample

Counsellors may come from many different professional backgrounds. In this study we have chosen an occupation specific approach, by collecting data from one specific group of counsellors, namely psychologists. Data was collected by means of anonymous self-report questionnaires distributed to 2,160 Norwegian psychologists. In Norway, the majority of psychologists work in a clinical setting, practicing counselling and therapy. The sample included 1,402 respondents (56.1% male and 43.9% female), yielding an overall response rate of 65%. The mean age of the sample was 41 years ($SD = 8.17$), ranging from 26 to 72 years. Among the respondents, 69.5% worked full-time, 43.5% had leadership responsibility (60.2% male and 53.3% female; mean age leaders 42 years ($SD=8,2$), non-leaders 40 ($SD=7,8$)). Average job tenure was 11 years, 10.2% of the respondents reported being a chief psychologist while 48 % were specialists approved by the Norwegian Psychological Association. As much as 43% worked in organizations with 1-10 employees, while 20% were employed at institutions with more than 100 employees. Of the respondents, 82.4% had children, 85.5% were married or cohabitants, while 14.5% lived alone.

Procedure

Data were collected by the use of the survey method. The questionnaires were distributed by post by the Norwegian Psychological Association (NPF). The response rate was good, approximately 65 % of those who got the questionnaire by mail responded.

Questionnaire

Demographic information constituted the first part of the questionnaire. Participants were asked to report their age, gender, number of subordinates, current employment status, civil status, and number of children.

Perceived social support. Perceived social support was measured by three items based on House (1981). The respondents were asked how much (1) practical support, (2) emotional support, and (3) constructive feedback they get from six different groups of people: leaders, co-workers within

the same profession, co-workers from another profession, union representatives, friends, and family. All six measures of perceived social support had satisfactory internal consistencies. Chronbach's alphas were: .84 (leader support), .82 (co-worker, same profession), .80 (co-worker, another profession), .81 (union representatives), .77 (family), and .77 (friends), respectively. The respondents were asked to rate their perceived level of support by means of four possible alternatives; "not at all", "a little", "a lot" and "very much".

Stress was measured by the Health Professions Stress Inventory (HPSI) (Wolfgang, 1988). The HPSI assesses both level and source of perceived stress of health professionals actively engaged in clinical practice. The measure contains 30 generally stressful situations gleaned from the literature, such as 'handling difficult clients'. Respondents are asked to identify how often they experience the particular situations using a 5-point Likert scale of "never", "seldom", "sometimes", "often" and "very often". In the present study, the HPSI had a satisfactory internal consistency, with Cronbach's alpha being .87.

Mental health was measured by 20 items from the General Health Questionnaire (GHQ; Goldberg, 1978), which is a measure of common mental health problems/domains, such as anxiety and depression. The GHQ was designed to be used as a screening instrument to identify psychological distress and short-term changes in mental health in community and health care settings (Goldberg & Williams, 1988; Penninkilampi-Kerola, Miettunen & Ebeling, 2006). The respondents were asked to indicate how often they had experienced different health conditions over the last two weeks. Examples of some items include: 'Have you found everything getting on top of you?'; 'Have you been getting scared or panicky for no good reason?' and 'Have you been getting edgy and bad tempered?'. Each item is accompanied by four possible responses, typically being 'not at all', 'no more than usual', 'rather more than usual' and 'much more than usual'. The mental health variable used in the analyses is a total sum score of all stressful situations measured in the GHQ. In the present study, the GHQ had a satisfactory internal consistency, with Cronbach's alpha being .91.

Statistics

Statistical analyses were conducted using the IBM Statistical Package for Social Sciences (SPSS) 19. Frequency, reliability and correlation analyses were employed on all the study's variables,

and hierarchical regression analyses were conducted in order to investigate the hypotheses. The mediator and moderator analyses were performed by steps recommended by Baron and Kenny (1986). The Sobel test for significance of indirect effects was used to test the possible indirect effect of leader support (<http://quantpsy.org/sobel/sobel.htm>). The level of significance was set to .05.

Results

The means, standard deviations, and correlations (Pearson's *r*) among the study's variables, including age and gender, are shown in Table 1. Age was related to gender, perceived stress, leader support, and social support from co-workers from another profession. Gender was related to friend support and perceived stress. The sources of social support were positively related to one another, with *r*'s varying between .12 and .42. Most sources of social support were related to perceived stress and mental health with the exception of social support from union representatives. Leader support showed the strongest correlation with mental health, as compared to the other sources of social support. Perceived stress and mental health correlated with one another.

Table 1.

Means, standard deviations, and correlations for the measured variables

Variables	1	2	3	4	5	6	7	8	9	10
1. Age										
2. Gender	-.07**									
3. Leader support	-.08**	-.06								
4. Co-worker ^a support	.02	.02	.36**							
5. Co-worker ^b support	.06*	.01	.31**	.34**						
6. Representative support	.06	-.02	.24**	.38**	.24**					
7. Family support	.05	-.03	.12**	.18**	.18**	.19**				
8. Friend support	.05	.18**	.14**	.24**	.21**	.25**	.42**			
9. Perceived stress	-.09**	.06*	-.29**	-.23**	-.13**	-.04	-.08*	-.08**		
10. Mental health	.01	.01	-.24**	-.17**	-.11**	-.05	-.16**	-.07*	.32**	
<i>M</i>	41.04	1.44	2.51	2.72	2.64	1.68	2.83	2.41	2.49	1.90
<i>SD</i>	8.17	0.50	0.78	0.72	0.68	0.67	0.75	0.74	0.41	0.35

Note. *N*= 980-1380. Gender: 1 = male, 2 = female. ^aco-worker from same profession, ^bco-worker from another profession. ** *p*<.01; * *p*<.05, two-tailed.

Table 2 shows the results of the regression analyses for different sources of social support as predictors of mental health, after controlling for age and gender. None of the control variables were significant predictors of health outcomes (step 1), while inclusion of the social support variables (step 2) resulted in a significant increase of the explained variance ($R^2 = .04, p < .001$). Moreover, inclusion of the leader support variable (step 3) resulted in a significant increase of the explained variance ($R^2 = .04, p < .001$), controlled for the other social support variables. For the linear effect, leader support acted as the strongest predictor of mental health ($\beta = .21, p < .001$) as compared to the other sources of support, where only support from co-workers from the same profession ($\beta = .15; p < .01$), other profession ($\beta = .07; p < .05$) and family ($\beta = .09; p < .01$) yielded significant contributions. Thus, the results support H1, that leader support has the strongest and an independent direct influence on mental health as compared to other sources of social support.

Table 2.

Hierarchical multiple regression analyses predicting mental health from leader support, as compared to other sources of support.

	Predictor	β	Mental health	
			R^2	ΔR^2
Step 1			.00	
	Age	-.01		
	Gender	-.00		
Step 2			.04***	.04***
	Co-worker support	.15**		
	Co-worker ^b support	.07*		
	Representative support	-.02		
	Family support	.09**		
	Friend support	-.03		
Step 3			.08***	.04***
	Leader support	.21***		

Note. ^bco-worker from another profession, *** $p < .001$; ** $p < .01$; * $p < .05$, two-tailed. listwise, N= 957.

Multiple regression analyses were employed in order to examine whether leader support acts as a moderator on the relationship between perceived stress and mental health (see Table 3). For the linear effect, perceived stress and leader support explained 12 % of the variance in health outcomes. Both perceived stress ($\beta = .27; p < .001$) and leader support ($\beta = -.16; p < .001$) yielded

significant contributions. Further, the interaction-term made a significant contribution to the explained variance ($\beta = -.08; p < .05$), resulting in a small but significant increase in the explained variance ($R^2 = .01, p < .05$). Thus, in support of H2 leader support was found to moderate the relationship between perceived stress and mental health.

Table 3.

Hierarchical multiple regression testing the moderating role of leader support on the relationship between perceived stress and mental health

Predictor	Mental health		
	β	R^2	ΔR^2
Step 1		.12***	
Perceived stress	.27***		
Leader support	-.16***		
Step 2		.13***	.01*
Perceived stress	.25***		
Leader support	-.16***		
Perceived stress x Leader support	-.08*		

Note. *** $p < .001$; ** $p < .01$; * $p < .05$, two-tailed, $N=792$.

To test for mediation (or whether leader support influences employees' stress perception, which again will influence their health), multiple regression analysis was utilized. According to Baron and Kenny (1986), mediation exists if the following criteria are met: (a) Leader support should significantly predict perceived stress and mental health, (b) perceived stress should significantly predict mental health, and (c) the effect of leader support on health should disappear or at least be reduced when perceived stress is added to the equation. These conditions are met in the present study. Leader support contributed significantly to the explained variance in mental health ($\beta = -.24; p < .001$). Further, perceived stress contributed significantly to a reduction in the effect of leader support on mental health (from $\beta = -.24; p < .001$ to $\beta = -.16; p < .001$). The Sobel test revealed that the mediating effect of perceived stress was significant ($p < .001$). This result supports H3 that the relationship between leader support and mental health is mediated by perceived stress. The leader support predictor remained significant, however, indicating stress to be a partial mediator between leader support and mental health.

Discussion

The results of the present study show that leader support is related to the mental health of Norwegian counsellors. With regard to the direct effect, leader support was found to be the strongest predictor of mental health, as compared to other sources of social support (e.g., friends and family), thus supporting H1. This finding of a stronger association between leader versus co-worker and non-work-related sources of support adds specific information to and supplements previous research and theoretical reasoning. For example, LMX theory (Graen & Uhl-Bien, 1995; Gottfredson & Aquinis, 2017) claims that supportive behavior from leaders is of particular importance to employees' strain reactions.

Also Ganster and colleagues' (1986) study of 326 employees in a contracting firm showed that sources of support from the workplace, especially from the leader, are crucial in affecting stressors and strain, as compared to support resources that are not directly work related. However, the present finding runs contrary to the study of 211 traffic enforcement agents, who showed that family support was more closely associated with health-related outcomes such as burnout than with satisfaction and productivity, whilst immediate supervisor support was related to satisfaction and productivity but not burnout (Baruch-Felman, Brondolo, Ben-Dayana & Schwartz, 2002).

One reason for the different findings regarding the extent of impact from different sources of social support on health may be due to the dissimilar organizational conditions under study. According to LaRocco, House and French (1980), occupational task structure and environment may play a role in determining which role of support is the most salient. For instance, in occupations where employees are performing structured and repetitive tasks, productivity may be a more salient concern for leaders which may also have more training in addressing work-related outcomes versus stress-related responses (Baruch-Feldman et al., 2002).

Psychologists, on the other hand, may work with more human-related issues, and Norwegian psychologist-leaders, in addition to authority and autonomy, may have the necessary human- or stress-related skill to provide support for individuals' health-related reactions, i.e., understanding the signs and causes of stress and what can be done to help, which is central to most psychologists in Norway. According to Rønnestad and Skovholt (2003), disappointments with self and with inadequate client progress can fuel a sense of inadequacy. Hence, many counsellors

will look for workplace mentors who will offer guidance and support. In the Rønnestad and Skovholt study, people most often mentioned were clients, professional elders (i.e., supervisors, personal therapists, professors, mentors), professional peers, friends, family members, and, later in one's career, younger colleagues.

The results of the present study indicate that social support from leaders may be of particular relevance for the mental health of psychologists. The main effect of leader support can be explained through the different functions of support itself. According to the leadership literature, social support from leaders may promote the experience of positive emotions (Glasø, Notelaers & Skogstad, 2011) and fulfills social needs, e.g., the sense of belonging and feelings of recognition (Hetland, Hetland, Andreassen, Pallesen & Notelaers, 2011). Alternatively, the present findings may also be explained by the "lack" of leader support. According to Carayon (1995), lack of social support from leaders may act as a chronic job stressor in itself. Research on loneliness (Cacioppo, 2002) provides ample evidence of the anguish, longing, and despair experienced by individuals who either lack or have lost important relationships.

Yet, the findings of the present study show that leader support not only directly influences mental health, but also acts as a buffer in the relationship between perceived stress and mental health. This is in line with H2, suggesting that social support from leaders may help counsellors cope with their stress experience and accordingly prevent it from impacting on health. Also Dormann and Zapf (1999) found a buffering effect on depression of social support from leaders in a three-wave study among citizens in Germany, using a time lag of 8 months. A possible account for this may be explained by the job-demand control-social support model (Karasek & Theorell, 1990), suggesting that job social support may facilitate successful coping with high-strain jobs (i.e., jobs with high demands, low control), as well as preventing or buffering the potentially harmful effects of these kinds of jobs. Following this notion, it is likely that counsellors, who have more access to leader support, may deal with work strain more effectively than those who experience less social support from leaders.

Further, while H2 proposes that leader support intervenes after stress perception by reducing the severity of the stress response, the results of the present study also support an indirect effect of social support, in that leader support directly influences perceived stress and subsequently the probability of ill-health. This means that social support may have a stress-preventive effect. This

finding, supporting H3, is in line with Thomas and Lankau (2009), who found that supporting leader behavior (measured in terms of LMX) serve as resources that minimize emotional exhaustion through decreased role stress. Theoretically this may be explained by the job demand-resources model (Bakker, Demerouti, DeBoer, & Schaufeli 2003), suggesting that leader support may alleviate the influence of perceived stress on health, because leaders' appreciation and support may take away the burden of profound demands. For example, by responding positively to followers' needs for support, autonomy, role clarity, and reduced ambiguity, leaders may substantially reduce work stress (Humphrey, Nahrgang & Morgeson, 2007). On the other hand, by ignoring the above issues or other factors, such as role overload or subordinates' needs for involvement, leaders may contribute significantly to followers' perceptions of such stressors (Bass, 1990; Nelson, Basu & Purdie, 1998). In sum, the results support the notion that leaders' behaviour is important with regard to subordinates' health, and show that there are multiple pathways through which leader support can influence mental health among counsellors.

Methodological Issues

It is important to note that the findings are captured from a cross-sectional survey study. This may indicate single source challenges or problems since independent variables and the dependent variable are mapped at the same point in time. Common method variance refers to a possible response bias in survey research, and may have enhanced the overall strength of correlations (see Podsakoff, MacKenzie, Lee & Podsakoff, 2003). Since data are cross-sectional, causal inference among the variables cannot be made. Longitudinal studies may help clarify the causality. Moreover, we have no knowledge of how many or which of the respondents are working together as colleagues in the same organization. Thus, multi-level analysis is not an option here.

Data were collected by the assistance of the Norwegian Psychological Association (NPF), which means that all of respondents are member of that specific union. It could be the case that counsellors standing on the outside of the union may be different from those being represented by the union, for instance in terms of work experience or work sector that constitute their daily work arena. The study indicated a low variance and a low level in perceived stress and mental health problems among Norwegian counsellors. It could be that the level of stress or mental health problems may be higher among those being on the outside of the NPF, as they receive less professional help from their organized colleagues. However, the opposite could also be the case,

were the group of non-organized counsellors may feel that they have a work day so free of substantial problems that they have no need of a membership in a union.

The present study is based on a large sample of counsellors, it has a relatively high participation rate, obtaining a response rate of 65 percent. It should be mentioned that the average response rate for studies that utilize data collected from individuals has been estimated to 53 percent, according to a meta study that captured the essence of 490 studies and 400 000 respondents (Baruch & Holtom, 2008).

Implications and Suggestion for Future Research

The present study has several practical implications. Firstly, as the results lend support to the notion that social support from leaders may have a direct and unique influence on subordinates' health as compared to other sources of social support, leaders should pay attention to their supporting role with regard to subordinates' mental health. Further, the findings that leader support influences subordinates' mental health in different ways highlights the importance of considering multiple perspectives in understanding the leaders' behavior and subordinates' health. Accordingly, different intervention strategies may be used to prevent work-related health problems among counsellors. For example, the moderating role of leader support suggests that leaders are in a position to influence or reduce stress-related reactions of more unchangeable inherent job characteristics (e.g., dealing with difficult client behavior).

Further, the indirect influence of leader support on health through stress perception implies that social support not only intervenes after the perception of stress and exerts its effect by reducing the severity of the stress responses, but also may reduce stress perception. Yet it should be noted that the moderator analysis shows that perceived stress also has a major effect on mental health, indicating that counsellors experience stress independent of social support variables. This implies that stress management strategies should focus on both the reduction of harmful work characteristics, such as the other demands of therapeutic work, as well as such positive factors as leader support.

The present study also has implications with regard to future research. Firstly, investigating of leader support with regard to other outcomes than mental health would be fruitful in order to

further understand the counsellors' work situation. Further, we encourage more systematic research into the question of whether some types of social support (e.g., instrumental, informational, and emotional support) are more or less important for specific health outcomes, as well as whether different sources of support (e.g., work related, non-work-related) may have different effects on health outcomes. Finally, longitudinal studies addressing leader support and both potential positive and negative health-related outcomes are clearly warranted.

Conclusion

The present study shows that leader support predicts counsellors' mental health more than peer support, family support and friend support, and that leader support moderates the effect of stress on mental health. As such, this paper contributes to an increased understanding of counsellors' need of social support, especially from their immediate superior. Learning about counsellors' need of social support is important in order to know how to keep and enhance their well-being and mental health, which again may ensure a high standard of quality when they execute their profession. Achieving a comprehensive understanding of counsellors' need of social support may also help us prohibit any negative factors related to their professional conduct, such as incompetence, impairment and burnout.

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