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**Doctoral Thesis**

# Clinical Psychologists' Experiences of Accessing Personal Therapy During Training

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**Word Count**

| Thesis Section | Text | Appendices (including references) | Total |
|---|---|---|---|
| **Abstract** | 296 | - | 296 |
| **Literature Review** | 8,000 | 6,548 | 14,548 |
| **Research Paper** | 8,000 | 15,876 | 23,876 |
| **Critical Review** | 3,982 | 906 | 4,888 |
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| **Totals** | 22, 054 | 28,094 | 50,148 |

## Abstract

This thesis is composed of three sections: A literature review of trainee therapists' experiences of supervision; a research paper exploring clinical psychologists' experiences of accessing personal therapy during training; and a critical appraisal which considers some of the issues encountered during the research process.

The literature review was conducted systematically, which resulted in fifteen qualitative studies for inclusion. A meta-synthesis was conducted with these studies. The findings suggest supervision can provide a number of learning opportunities for trainee therapists, and support them both personally and professionally. However, the efficacy of supervision appears to depend substantially upon the supervisory relationship. This includes the power differential between a supervisor and supervisee, such as whether a trainee fears negative evaluation if they raise concerns or difficulties. Implications for training courses are discussed, including recommendations for supervisor training courses.

The research paper explores the experience of accessing personal therapy whilst undertaking clinical psychology training. Ten clinical psychologists were recruited and interviewed. The interviews were analysed using narrative analysis. The findings suggested personal therapy had a positive impact on participants both personally and professionally. They described a number of difficult experiences during the process, including a perceived stigma of accessing therapy as a trainee therapist. Participants also reflected on the role of personal therapy in supporting them through the stressors of clinical training. Implications for both clinical psychology training programmes and the profession are discussed, in addition to ideas for future research.

The critical appraisal discusses particular aspects of the research process. This includes deciding to research personal therapy and reflections on the difference between a research interview and a therapy session. This section also considers decisions and

challenges encountered using a narrative approach, both at the interviewing and analysis stages. Finally, the personal impact of the research is discussed.

## Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at Lancaster University's Division of Health Research from June 2013 to May 2014.

The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name:

Signature:

Date:

**Acknowledgements**

Firstly, I would like to thank the ten individuals who shared their stories with me. I would also like to thank both of my supervisors, Jenny Davies and Ste Weatherhead, for their time and support throughout the process. My sincere thanks to Emma Hickey for her input, despite an ever-growing workload!

I owe a big thank you to my Mum and Dad, who provided numerous draft reads, food parcels and words of encouragement. Similarly, thank you to my friends who have been my cheerleaders. I would also like to thank each and every one of my cohort; without you, the last three years could have been a very different experience. Thank you for keeping me sane, and for the never-ending stream of motivational pictures.

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**Abstract**

**Purpose:** Supervision is typically mandatory for therapists in training, and plays an important role in their professional development. A number of qualitative studies have considered specific aspects of supervision. This systematic review aimed to synthesise these studies' findings, and explore the experience and impact of supervision for trainee therapists.

**Method:** A systematic search of the literature was conducted, and inclusion/exclusion criteria were applied. This led to a sample of 15 qualitative studies, with which a meta-synthesis was conducted.

**Results:** The meta-synthesis led to four key concepts: Supervision as a learning opportunity; the supervisory relationship; power in supervision; and the impact of supervision. These themes explored helpful and unhelpful aspects of supervision, including some concerns regarding the evaluation of supervision.

**Conclusion:** Supervision can effectively support trainee therapists in their personal and professional development. However, it can also lead to feelings of distress and self-doubt. Supervisors need to consider the power differential within supervision, and attend to different factors within the supervisory relationship.

**Practitioner points:**

- Supervision is a mandatory requirement for the majority of therapists in training, which can encourage personal and professional development
- Supervision can have a detrimental impact on trainee therapists' wellbeing, and consequently their clinical work and clients' experiences
- Supervisees may not disclose unhelpful events or impacts from supervision, for fear of negative evaluation

# Trainee Therapists' Experiences of Supervision during Training: A Meta-synthesis

Supervision is defined as "an intervention provided by a more senior member of a profession to a more junior colleague" (Bernard & Goodyear, 2013, p. 9). This review focuses on supervision for therapists in training, accessed by those from a range of disciplines in relation to their clinical work. Many models of clinical supervision have been developed, which emphasise its role within continuing professional development (Fleming & Steen, 2004). The British Psychological Society (BPS)'s Division of Counselling Psychology describe supervision as "designed to offer multi-level support in an atmosphere of integrity and openness for the purpose of enhancing reflective skills, maximising the effectiveness of therapeutic interventions, informing ethical decisions and facilitating an understanding of the use of self" (2005; p.5). The ethical requirement for practitioners to receive regular supervision from an appropriate professional is also emphasised.

Accessing supervision is considered vital across a range of psychological models and disciplines (Wheeler & Richards, 2007). The American Psychological Association (APA; 2014), Australian Psychological Society (APS; 2003) and BPS (2013) all specify a minimum level of contact time with supervisors during training for practitioners. Similarly, the British Association for Counselling and Psychotherapy (2002) dictate all practising counsellors and therapists should receive supervision, regardless of career stage.

Supervision is mandatory for therapists in training, but its function and style can vary. This review will first consider the purpose of supervision for therapists training to deliver talking therapies through an accredited programme[1]. It will then explore the importance, efficacy and quality of supervision, before presenting a meta-synthesis of studies regarding these experiences.

[1] Programmes are accredited by various bodies in different countries, such as the American Psychological Association, Australian Psychological Society, and the British Psychological Society

**Purpose of Supervision**

Supervision has been described as an "essential prerequisite for the practice of psychotherapy" (Roth & Fonagy, 1996, p. 373) and "the primary component and most frequently used method for teaching therapy" (Milne & James, 2002, p. 55). The BPS (2008) suggests "all aspects of practice should be accessible to discussion in supervision including research activity, administrative and managerial work, service developments, team working, teaching and the process of supervising others" (p. 16). Studies suggest trainees' supervision requirements differ depending on their developmental level, moving from skill-acquisition to personal development (Worthen & McNeill, 1996). However, there are core aspects which supervision is designed to address. Falender and Shafranske (2004) group these into two tasks: "to ensure the integrity of clinical services provided to the client and to develop competence in the supervisee" (p. 3). This encompasses clinical governance, and developing skills, knowledge and professional identity.

Supervision provides an opportunity to socialise trainees to the profession and particular models (Falender & Shafranske, 2004). The feedback and reflection which supervision provides is considered essential to trainees acquiring and developing skills, which would not occur through exposure to clinical work alone (Bernard & Goodyear, 2013; Binder, 1993). A supervisor's attitudes, knowledge and skills can influence those of a supervisee, both directly and indirectly (Brown & Landrum-Brown, 1995).

In addition to supporting skill development, supervision is expected to monitor ethical and professional behaviour. This includes attending to aspects of power, following professional guidelines, and protecting clients' safety (Milne & James, 2000; Wheeler, 2004). Supervision can also provide emotional support to trainee therapists, as they are expected to quickly assimilate to the role of "professional helper" (De Stefano et al., 2007, p. 42) despite anxieties and uncertainties. Enhanced trainee confidence, motivation and therapeutic

perceptiveness are potential outcomes from positive supervisory experiences (Nelson & Friedlander, 2001). Self-efficacy has been described as "the primary causal determinant of effective counselling action" (Larson & Daniels, 1998, p. 180), and therefore anything which contributes to its development is worthy of attention.

There is an inevitable element of evaluation within supervision for trainee therapists. Whilst assessing supervisees' performance, the supervisor retains ultimate responsibility for their work (Falender et al., 2004). There has been an increase in emphasis on supervised practice in response to greater demands for accountability within the National Health Service (Wheeler, 2004). This increased pressure on certain functions of supervision may affect the supervisory relationship, as "both supervisor and supervisee can experience evaluation with discomfort" (Bernard & Goodyear, 1998, p. 9). There has been minimal research exploring the evaluative component of supervision, and how supervisors judge trainee competence (Bambling, King, Raue, Schweitzer, & Lambert, 2006). This may be partly due to the noted discomfort, and consequently focussing on aspects of supervision such as the relationship or model.

To achieve the functions above, supervisors may employ a particular supervision model. There are a number of published models, broadly separated into: Those centred on psychotherapy theories; developmental models; and process models (Bernard & Goodyear, 2013; Falender & Shafranske, 2004). Psychotherapy-based approaches are informed by clinical approaches and techniques, including theoretical orientation (Falender & Shafranske, 2004). They provide modelling opportunities, but can require trainees to commit to an approach they may not have chosen (Bernard & Goodyear, 2013). In contrast, developmental models focus on a supervisee's level of development (Beinart, 2004). These approaches encourage supervisors to attend to the differing needs of trainees (Bernard & Goodyear, 2013), which relies on supervisors correctly interpreting a trainee's developmental stage.

Finally, process models explore the supervision process itself (Bernard & Goodyear, 2013; Falender & Shafranske, 2004). These can be used in conjunction with other models, and encourage both supervisor and supervisee to consider their expectations and attitudes towards supervision.

Whilst supervisors may be informed by different supervisory models, the core aims of supervision remain the same: Teaching and learning; and monitoring clients' welfare (Bernard & Goodyear, 2013). These aims have a number of potential impacts upon clients' and trainees' experiences.

**Impact of Supervision**

Efforts to quantify the efficacy of supervision have met methodological difficulties (Wheeler, 2004). A review of supervision literature 1981-1993 suggested "investigations of supervision were simultaneously unlikely to detect true effects and very likely to find spuriously significant results" (Ellis, Ladany, Krengel & Schult, 1996, p. 43). More recently, Milne and James (2000) conducted a review of cognitive behavioural supervision, and demonstrated positive impacts on client outcomes. However, these outcomes relied predominantly on simple behavioural measures; therefore the significance of their findings is unclear. Research with qualified therapists indicated a significant effect of supervision on clients' satisfaction with therapy and reduction in depressive symptoms (Bambling et al., 2006), but this may not apply to trainee therapists.

Whilst there is a lack of strong empirical evidence to support direct links between supervision and client outcome (Wheeler & Richards, 2007), some authors have explored indirect impacts. A review by Holloway and Neufeldt (1995) outlined several factors which contribute to treatment efficacy, which supervision may affect. These included the therapist's ability to: Case conceptualise; select and conduct interventions; and follow intervention plans consistent with specific models. In addition, O'Donovan, Halford and Walters (2011)

describe supervision's role in noticing clients' responses to therapy, and adjusting a supervisee's work if necessary. Whilst positive client outcomes are the ultimate goal, supervision addresses a number of aspects which contribute to this in different ways.

Supervision also supports supervisees to consider the impact of their own experiences and recognise their "blind spots" (Morrissey & Tribe, 2001, p. 105). Increased self-awareness may enable therapists to better distinguish between the emotions of themselves and their clients (Kumari, 2011). Ancis and Marshall (2010) conducted qualitative interviews with trainee therapists, who suggested supervision allowed them to recognise biases and assumptions. Participants thought this process positively affected client outcomes, as they were more able to attend to aspects of difference within the therapeutic relationship. Wheeler and Richards (2007) conducted a review of the published literature, and found several studies supporting the notion of supervision increasing self-awareness. However, training for therapists often includes opportunities for reflection and developing self-awareness. It is difficult to know how much development can be attributed to supervision, as opposed to the cumulative experience of training.

In addition to self-awareness, supervision can affect a trainee's professional confidence (Nelson & Friedlander, 2001; Wulf & Nelson, 2001). Where trainees perceive failure within their clinical work, supervision can support their continued self-competence (De Stefano et al., 2007). The perceived safety of supervision is likely to impact on the disclosure of trainee fears and vulnerabilities. For example, trainees interviewed by Ladany et al. (1997) reported disclosing sexual attraction towards clients in supervision, to "explore and cope with" the experience (p. 419). However, those who did not disclose it in supervision typically discussed it with peers or therapists; consequently they may have received similar support in processing the event, but from a different source.

Supervision can also provide emotional support to trainee therapists. This reduces the likelihood of trainees being distracted by their emotions within clinical work (Vallance, 2004), and provides an opportunity to normalise difficult experiences (Knox, Burkard, Jackson, Schaak, & Hess, 2006). In addition to distraction, trainee emotions may also affect their self-confidence. Counterproductive events in supervision can decrease a trainee's confidence in their ability, withdrawing from the supervisory relationship or discounting their supervisor's input (Gray, Ladany, Walker & Ancis, 2001). Each of these aspects of supervision can affect a therapist's competence and confidence, and consequently a client's experience of therapy.

**Quality of Supervision**

Due to the inherently personal nature of supervision, it is difficult to define successful supervision (Milne, Pilkington, Gracie & James, 2003). Falender and Shafranske (2004) suggest effective supervision is built on three aspects: The supervisory relationship; thinking critically about therapeutic processes; and learning strategies. As part of training, supervision can be experienced as both helpful and detrimental. Cushway (1992) conducted a survey of trainees, and found supervision featured amongst both the top five stressors, and top five coping strategies, of training, suggesting supervision can both "punish and reward" (Cushway & Knibbs, 2004, p. 162). Consequently, it is important to consider how to ensure supervision is not experienced as an additional stressor.

Carifio and Hess (1987) claimed:

> High-functioning supervisors perform with high levels of empathy, respect, genuineness, flexibility, concern, investment, and openness. Good supervisors also appear to be knowledgeable, experienced, and concrete in their presentation. They use appropriate teaching, goal-setting, and feedback techniques during their

> supervisory interactions. Last, good supervisors appear to be supportive and non-critical individuals who respect their supervisees (p. 244).

Folkes-Skinner, Elliott and Wheeler (2010) also suggested the role of supervision in providing reassurance to trainees can be important in validating their work and decisions.

Qualitative interviews with trainee therapists indicated open discussions in supervision reduced fears and encouraged self-disclosure or discussion of difficult topics (Ancis & Marshall, 2010; Bottrill, Pistrang, Barker & Worrell, 2010). Not allocating space for these discussions resulted in trainees feeling they had to "figure things out for themselves" (Bottrill et al., 2010, p. 174). Observing supervisors handling these topics within clinical sessions was considered useful, although could be unhelpful where trainees disagreed with their supervisor's practice.

Throughout the wealth of research exploring supervision, the relationship between supervisor and supervisee is highlighted as the most important factor in its success (Holloway, 1995; Kilminster & Jolly, 2000; Ladany, Ellis & Friedlander, 1999). The BPS (2013) stipulates "supervisors should be sensitive to, and prepared to discuss, personal issues that arise for trainees in the course of their work" (p. 31). Collaboration between supervisor and supervisee has been highlighted as a key component of supervision (Ratcliff, Wampler & Morris, 2000), with elements such as trust, understanding and acceptance highly valued (Wheeler, 2004). The need for these aspects may be enhanced due to the potential vulnerability of trainee therapists and the role of supervision in their assessment. A case study by Stromme and Gullestad (2012) demonstrated the intense anxiety for a trainee therapist receiving judgement from their supervisor, which impacted upon their sense of self-efficacy. Whilst only based on one individual, it suggests appraisal may be implicitly prominent in trainees' supervision. As the supervisor plays the role of "evaluator, assessor, gatekeeper and transmitter of values for the profession" (Patel, 2004, p. 109), it is important

to acknowledge the power dynamics within the supervisory relationship. Patel suggests failure to explicitly address the power relations within supervision can lead to coercion, as opposed to collaboration, which may negatively impact client work.

**Rationale for a Meta-synthesis**

Supervision for therapists in training is an important issue to explore, not least because "about one half of a professional psychologist's formal training involves learning through supervision" (Bent, Schindler, & Dobbins, 1991, p. 124). Much of the past research regarding supervision has involved responses to questionnaires, which lack the ability to fully explore what happens within supervision (Reichelt & Skjerve, 2001).

More recently, a number of qualitative studies have been conducted to investigate particular aspects of supervision, such as self-disclosure or perspectives of power. This can provide a richer understanding of supervisees' experiences than quantitative studies, as exemplified by Milne et al. (2003) in their exploration of the transference of skills from supervision to therapy. Although the specific focus of these qualitative studies can limit their generalisability, there may be common factors which feature across each of these specific experiences. Having a broader understanding of this may be of benefit to supervisors and supervisees.

Although supervision requirements vary across countries, disciplines and therapeutic orientations, it is typically mandatory for trainees (Wheeler & Richards, 2007). In addition, training may be the time where supervision has the most influence, as trainees rapidly gain both experience and skills. Therefore, this meta-synthesis looks at the experiences of supervision for therapists in training. As there has historically been a lack of effort to provide training or support for supervisors (Milne & James, 2002), it is hoped that additional information regarding supervisory encounters will support supervisors to provide effective supervision.

## Method

The aim of a qualitative meta-synthesis is to develop new knowledge, based on analysis and synthesis of existing qualitative research (Thorne, Jensen, Kearney, Noblit & Sandelowski, 2004). Using a systematic approach, individual findings are examined, interpreted and integrated into conclusions more substantive than those from the original investigations (Finfgeld, 2003). Consequently, the data-analysis aims to produce a developed understanding of the experience of supervision for therapists in training.

### Data Collection

The following databases were searched in January 2014: MedLine; PsycArticles; PsycInfo; Web of Science. A Boolean search was conducted to allow the following terms and phrases to be combined:

- Psychologist in training OR trainee psychology* OR trainee therap* OR psycholog* graduate OR therap* training OR psycholog* intern OR therap* student OR psycholog* student OR trainee counsel*
- Qualitative OR interview OR focus group
- Supervis*

No other expanders or limiters were selected. A total of 104 papers were screened for eligibility. Figure 1 demonstrates how the final sample of studies was reached.

The following inclusion criteria were applied, in order for studies to be considered: Written in English; qualitative design using interviews or focus groups; exploring experiences of retrospective supervision; concerning the experience of therapists in training. 'Therapist in training' was defined as any individual learning to deliver a talking therapy through an accredited route, regardless of model or stage of training.

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Figure 1 around here

Studies which met the inclusion criteria were further examined, and exclusion criteria applied as follows. Studies were excluded if the analysis was conducted with responses from non-trainee therapists, such as supervisors, in addition to therapists in training, as interpretation was not therefore solely based on trainee therapists' responses. Studies were also excluded if the findings presented were not well supported by raw data. Finfgeld (2003) describes this as a fundamental selection criterion when conducting a meta-synthesis. It is also present within quality appraisal tools such as the Critical Appraisal Skills Programme (CASP; 2013). Finally, any studies whose findings were not presented as themes were also excluded. This was to better enable comparison and contrast across the studies (Sandelowski, Docherty, & Emden, 1997). This process led to a final sample of 15 studies.

**Appraising the Quality of the Selected Studies**

According to Walsh and Downe (2006), including studies with flawed methodologies within a meta-synthesis may lead to an equally flawed end product. However, as Barbour (2001) suggests, applying a multitude of technical procedures to qualitative research may compromise its uniqueness. Although some authors report using quality appraisal as a further inclusion/exclusion criterion in systematic reviews, this risks excluding relevant data. There is also a risk of confusing the "adequacy of a description of something in a report with the appropriateness of something that occurred in the study itself" (Sandelowski & Barroso, 2007, p. 136). As noted above, the only exception was to exclude studies where analysis was conducted with responses from participants other than therapists in training, or where findings were not adequately supported with raw data. These steps were taken to ensure the interpretations presented within the meta-synthesis were as valid as possible.

It was still considered important to conduct a full appraisal of each included study, in order to assess its quality. This allows description of the range of quality within the studies,

and reflection on the contribution of different quality papers to the final synthesis (Atkins et al., 2008). The CASP (2013) was utilised, which is comprised of 10 items concerning the credibility, rigour and relevance of the research. As suggested by Duggleby et al., (2010), for each item a score was assigned. A '3' denoted presenting extensive justification and meeting criteria, '2' denoted addressing, but not elaborating on, the issue, and '1' denoted a substantial lack in meeting the criteria or presenting any justification (see Table 1). No studies received a '3' on all items, but the majority were of relatively good quality. Items such as appropriate design, reflexivity and ethical concerns were commonly not fully met. It is worth noting that although all studies were considered to employ an appropriate design to achieve their aim, the majority did not explicitly discuss their rationale for its use. For each study, the scores were totalled, with a maximum possible score of 30.

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Table 1 around here

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**Characteristics of the Selected Studies**

This meta-synthesis includes data from 165 participants across 15 separate studies. The papers were published across a 16 year period, between 1996 and 2012. Demographic and descriptive data regarding the participants and methods within the 15 studies is presented in Table 2 and Table 3.

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Table 2 & 3 around here

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The sample includes a variety of therapists in training, including clinical and counselling psychologists, and family therapists. Nine of the 15 studies took place within the USA, three in the UK and one each in Australia, Canada and Norway. Almost 61% of participants were female. The studies utilised a number of methodological approaches, with grounded theory or consensual qualitative research accounting for nine of the papers.

**Data Analysis**

The goal of a qualitative meta-synthesis lies in interpretation rather than aggregation (Thorne et al., 2004). It requires a rigorous examination and interpretation of each study's findings, as opposed to the raw data (Jensen & Allen, 1996). In order to achieve a synthesis of the papers whilst preserving the data within, a meta-ethnographic method was followed as described by Noblit and Hare (1988). This approach's process of induction and interpretation is suggested to more closely resemble the qualitative methods of those studies it seeks to synthesise than some traditional methods (Britten et al., 2002).

Noblit and Hare describe a seven-step process when conducting a meta-ethnography: Getting started; deciding what is relevant; reading the studies; determining how studies are related; translating studies into one another; synthesising translations; and expressing the synthesis. These steps are iterative, rather than a discrete, linear process (Pope, Mays & Popay, 2007). Steps one and two were achieved through conducting a literature search and applying both inclusion and exclusion criteria to determine the relevant studies. The included papers were read several times, to familiarise the author with the content. Whilst reading each paper, concepts, themes and interpretations presented by the authors were noted. The concepts or metaphors from each paper were then compared and contrasted, to explore if and how the studies were related. Table 4 demonstrates an example of the themes which led to one of the final concepts; power in supervision.

Table 4 around here

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This process developed a set of key concepts, which encompassed the themes and metaphors within each paper. The data were examined for any themes, metaphors or concepts which refuted the developing interpretation. The final synthesis was expressed as four key concepts. Table 5 demonstrates which studies contributed to each key concept.

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Table 5 around here

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## Findings

The findings presented below reflect the themes and interpretations described within the selected studies, and are grouped into the following concepts: Supervision as a learning opportunity; the supervisory relationship; power in supervision; and the impact of supervision.

### Supervision as a Learning Opportunity

Thirteen of the studies included themes relating to different learning opportunities which arose from supervision. Particular processes within supervision, such as Socratic dialogue, facilitated deeper and more meaningful learning for participants (Johnston & Milne, 2012). The technique promoted a "sense of ownership" (p. 14) when participants discovered their own answers. However, this could be unhelpful if participants struggled to access their own knowledge; one participant noted "at times I feel that he is bating me to something he has thought out himself. He should rather be clear about it than keep me guessing" (Reichelt & Skjerve, 2001, p. 34).

Participants valued supervisors providing advice on alternatives (Bottrill et al., 2010; De Stefano et al, 2007; Folkes-Skinner et al., 2010; Murphy & Wright, 2005; Reichelt & Skjerve, 2001). This included alternative ways to approach particular issues, and possible explanations for participants' own feelings such as frustration or incompetence (Bottrill et al., 2010; De Stefano et al., 2007; Folkes-Skinner et al., 2010). It was important that alternative suggestions were not accompanied by pressure to act on them (Murphy & Wright, 2005; Reichelt & Skjerve, 2001). Participants reported an "eagerness to return to their clients with their new understanding" (Worthen & McNeill, 1996, p. 31) having sought advice through supervision.

There was some variation between participants' hopes for the focus of supervision, with regards to their learning. Some participants requested more practical support and "wanted their questions concerning what to do to be answered more clearly" (Johnston & Milne, 2012; Reichelt & Skjerve, 2001, p. 33). Other participants focussed on supervision's role in developing their conceptualisation of clients, rather than specific skills (Worthen & McNeill, 1996). Some supervisors considered specific tasks at the expense of developmental processes, which led participants to report a lack of preparedness for life after training (Wulf & Nelson, 2001).

Feedback from supervisors also enabled participants' learning, and encouraged their development. This could be providing "expert opinions on how supervisees' skills needed to change" (Murphy & Wright, 2005, p. 288) or noting positives in supervisees' performance. Participants suggested reassurance of their clinical competency allowed further skill development, and engagement with deeper complexity of client work (Worthen & McNeill, 1996).

Observation of supervisors was suggested to contribute significantly to participants' learning and development (Bottrill et al., 2010; Burkard, Knox, Hess & Schultz, 2009; Gray

et al., 2001; Rhodes, Nge, Wallis & Hunt, 2011; Wulf & Nelson, 2001). Participants appreciated supervisors who demonstrated values such as respect for others and honesty regarding their fallibility. Observing supervisors allowed participants to consider different ways to handle situations, including what not to do in their own practice (Bottrill et al., 2010; Wulf & Nelson, 2001). Potentially unhelpful events such as supervisors imposing their own theoretical style also encouraged supervisees to consider alternative ways they could handle similar situations (Gray et al., 2001; Murphy & Wright, 2005; Wulf & Nelson, 2001).

Participants appreciated supervisors who facilitated thinking about the "metaperspective" (Worthen & McNeill, 1996, p. 31) such as the purpose of therapy, the therapeutic relationship, and theories of change (Bottrill et al., 2010). Reflection on supervision allowed the learning process to continue beyond the session (Johnston & Milne, 2012; Wulf & Nelson, 2001). One participant recalled:

> Supervision will come back to me when I'm sitting thinking about a case formulation or I'm worried about a particular client, and I'm out walking the dog, and there will be that kind of flash of 'ooohhh' and it's like the pennies kind of been filtering through and reached a place where it makes sense and fits (Johnston & Milne, 2012, p. 14).

For some participants, there was a lack of opportunity for reflection within supervision (Bottrill et al., 2010), which could "leave them feeling that they had to figure things out for themselves without sufficient support" (p. 174). This diminished focus on reflection could result from time pressures, and fears of negative evaluation for raising particular topics.

The different learning opportunities within supervision allowed participants to build their confidence and professional identity (Murphy & Wright, 2005; Perry, 2012; Worthen & McNeill, 1996). It also increased their multicultural awareness (Ancis & Marshall, 2010). Supervisors who "empowered by emphasising and capitalising on supervisees' knowledge

and wisdom" (Murphy & Wright, 2005, p. 288) encouraged participants to make confident decisions regarding their clients.

**Supervisory Relationship**

Aspects of the supervisory relationship were discussed in 11 of the papers, with both positive and negative experiences. Worthen and McNeill (1996) state "the most pivotal and crucial component of good supervision experiences…was the quality of the supervisory relationship" (p. 29). Words used to describe positive supervisory relationships included "supportive," "caring," "open," "collaborative," "sensitive," "flexible," "helpful," "non-judgemental," "inquisitive," and "challenging" (Gray et al., 2001; Johnston & Milne, 2012; Marshall & Wieling, 2003; Murphy & Wright, 2005; Reichelt & Skjerve, 2001; Worthen & McNeill, 1996). One participant suggested this was a combination of "personal caring but with never a loss of sight of the professional" (Wulf & Nelson, 2001, p. 131). Respect was also important within the supervisory relationship, both personally and professionally, such as maintaining the agreed time or space for supervision (Johnston & Milne, 2012; Worthen & McNeill, 1996).

Participants appreciated supervisors who were open regarding the strengths and limitations of their own knowledge (Ancis & Marshall, 2010). They also valued supervisors who accepted and explored the differences between them, allowing supervisor and supervisee to learn together (Ancis & Marshall, 2010; Burkard et al., 2009; Marshall & Wieling, 2003). This enhanced the supervisory relationship, and increased participants' confidence (Ancis & Marshall, 2010; Marshall & Wieling, 2003; Murphy & Wright, 2005). Events where supervisors displayed acceptance of issues of diversity also helped to strengthen the supervisory relationship (Burkard et al., 2009; Marshall & Wieling, 2003).

Supervisors' self-disclosure was perceived positively, particularly regarding their own experiences and values (Ancis & Marshall, 2010; Worthen & McNeill, 1996). This helped to

normalise supervisees' experiences and encouraged participants to share their own perspectives (Ancis & Marshall, 2010; Bottrill et al., 2010; Worthen & McNeill, 1996). It was also appreciated when supervisors were open regarding the limits of their own competence (Ancis & Marshall, 2010). These factors contributed to developing participants' self-awareness and professional confidence. The supervisory relationship was important in facilitating this growth, which was difficult when "sometimes people don't fit with their supervisors" (Wulf & Nelson, 2003, p. 138).

There was also discussion of negative events in supervision. This was largely explored in papers with a specific focus on negative aspects of supervision, but was also briefly discussed in other included studies. Where these events occurred, the safety of the supervisory relationship was greatly impacted (Burkard et al., 2009; Gray et al., 2001). This could lead participants to cease addressing clinical issues with their supervisor, and affected their sense of being "good enough" (Gray et al., 2001). Words used to describe unhelpful supervisors included "impatient," "uncommitted, "late," "inconsistent," and "not empathic" (Gray et al., 2001; Johnston & Milne, 2012; Nelson & Friedlander, 2001). Although possible for supervisory relationships to improve or recover, this required acknowledgement and support from the supervisor. Alternatively, it required an adaptation from the trainee, such as growing "thicker skin" (Gray et al., p. 377).

Aspects of supervision experienced as less helpful included unproductive or unprepared sessions/supervisors, and displaying favouritism (Burkard et al., 2009; Murphy & Wright, 2005). Supervisors could also be "preoccupied with his or her own ideas" (Reichelt & Skjerve, 2001, p. 32). One participant described a supervisor who "whenever I criticized his criticism, he would just get furious. He screamed at me a couple of times; just weird stuff." (Wulf & Nelson, 2001, p. 130). Although participants wished their supervisors had acknowledged counterproductive events in supervision, their feelings were typically

undisclosed to supervisors. Consequently, the event was unresolved (Gray et al., 2001; Nelson & Friedlander, 2001).

**Power in Supervision**

Aspects of power in supervision were explored by nine of the studies, with supervisors either implicitly or explicitly discussing it (Ancis & Marshall, 2010; Murphy & Wright, 2005). The experience and impact of the power differential appeared to be more significant than other aspects of the supervisory relationship, and consequently it was explored within a separate theme. Negative supervision events often centred on aspects of power, such as dismissing participants' thoughts and feelings, or supervisors exploring their own agenda (Gray et al., 2001; Johnston & Milne, 2012; Nelson & Friendlander, 2001). One participant:

> …tried to tell the supervisor that she did not believe the supervisor's suggestion fit the client's issues, to which the supervisor replied that she had been wrong in the past, but not too often, and that this was not one of those cases (Gray et al., 2001, p. 376).

Certain aspects of supervision were inextricably linked to concepts of power, particularly evaluation (Bottrill et al., 2010; Johnston & Milne, 2012; Murphy & Wright, 2005; Wulf & Nelson, 2001). Although participants recognised the importance of learning their own strengths and weaknesses, fear of negative evaluation impacted on their comfort in raising difficult topics in supervision (Bottrill et al., 2010; Burkard et al., 2009; Gray et al., 2001). One participant commented, "it's intrinsically quite a threatening process to go into; to be honest and open so that you can benefit, but doing that with the person that's your judge and executioner" (Johnston & Milne, 2012, p. 11). When participants felt able to initiate discussions of counterproductive events within supervision, there could be both positive and negative consequences (Gray et al., 2001; Nelson & Friedlander, 2001). Some participants

also perceived their supervisor as "biased or oppressive" (Burkard et al., 2009) based on their reactions to topics such as sexual orientation.

Participants reported direct violations of supervisors' power, such as sharing inappropriate information or following their own agenda (Murphy & Wright, 2005; Nelson & Friedlander, 2001). One participant's supervisor revealed "highly explicit details of his sexual activities to her" (Nelson & Friedlander, 2001, p. 390). The participant feared possible recriminations if she complained, and consequently remained silent. Where difficulties in the supervisory relationship occurred, supervisees felt "uncertain and unsafe in supervision" (Burkard et al., 2009, p. 183) and began to distrust their supervisor's advice. Instances where participants felt powerless in supervision could also lead to feelings of stress and self-doubt, assuming "it must be what I am doing. It must be my fault" (Nelson & Friedlander, 2001, p. 291).

Supervisors' misuse of power, such as intrusive actions or breaking confidentiality, led to an unsafe supervisory relationship (Burkard et al., 2009; Murphy & Wright, 2005, p. 290). This led participants to distrust their supervisor's advice, or self-criticise (Burkard et al., 2009; Gray et al., 2001). In contrast, supervision perceived as safe was described with words such as "confidential," "open," "non-judgemental," "supportive," and demonstrated "an effective use of power" (Ancis & Marshall, 2010; Murphy & Wright, 2005). Feeling safe within supervision allowed participants to be vulnerable, and take risks in questions or challenges (Ancis & Marshall, 2010; De Stefano et al, 2007; Gray et al., 2001; Murphy & Wright, 2005). Where participants did not experience this safety, they often chose not to disclose their own feelings, which could impact on their clinical development (Murphy & Wright, 2005).

Although the majority of themes regarding power referred to the supervisor, there were also responses regarding power held by the supervisee (Ancis & Marshall, 2010;

Murphy & Wright, 2005). It was noted "as a group, we might have more power than our supervisors and we influence what happens by going to the director of the program if we're not satisfied with what's going on" (Murphy & Wright, 2005, p. 291). Participants were also empowered by the ability to warn peers about supervisors who were not experienced as competent or respectful. The role of supervisees as consumers was also highlighted, where they themselves funded their supervision (Murphy & Wright, 2005).

**Impact of Supervision**

There were several impacts of supervision described by participants, both personally and professionally. Participants described feeling "affirmed, validated, and respected" when supervisors reacted positively to their identities (Burkard et al., 2009, p. 182). Normalising participants' feelings was also "comforting" and "reassuring" (Folkes-Skinner et al., 2010) and helped to increase confidence in client work (Worthen & McNeill, 1996).

Supervision provided a space to process feelings, both regarding clients and colleagues (Burkard et al., 2009; Rhodes et al., 2011; Worthen & McNeill, 1996), although some participants wanted more opportunity to discuss personal aspects of the therapist role (Reichelt & Skjerve, 2001). Participants valued the safety to discuss the links between personal and professional issues, and suggested these opportunities allowed the development of an internal supervisor (Rhodes et al., 2011; Worthen & McNeill, 1996).

Supervisors were able to comment on trainee strengths and weaknesses, which was received both positively and negatively (Ancis & Marshall, 2010; Wulf & Nelson, 2001). Where feedback was overly negative, participants could feel they were "being picked at and criticized a lot" (Wulf & Nelson, 2001, p. 129). Negative events like this could lead to emotions such as anger, fear, distress, frustration, anxiety and shock (Burkard et al., 2009; Gray et al., 2001). Participants described losing trust in their supervisor and withdrawing from the relationship (Nelson & Friedlander, 2001).

Participants managed counterproductive events in supervision by "trying to be agreeable or trying not to be defensive" (Gray et al., 2001, p. 376). However, feelings of self-doubt and confusion were often experienced. Some participants strove to recognise their own role in the supervisory difficulties, and utilised support from others (Nelson & Friedlander, 2001). Coping successfully with episodes of conflict or negativity strengthened some participants' sense of self and resilience (Nelson & Friedlander, 2001). However other participants' sense of self became uncertain as they felt pressured to be a "clone" of their supervisor (Wulf & Nelson, 2001, p. 134). Some also began to doubt their profession's level of acceptance and knowledge, reflecting "I don't think I want to be involved with the hard line mental health type attitude or people" (Burkard et al., 2001, p. 391).

Participants reported a number of ways in which supervision affected their client work. They were encouraged to understand the client's perspective, including "the relationship between a client's presenting problem, situational events, and diversity considerations" (Ancis & Marshall, 2010, p. 281). Participants appreciated when supervision included space to reflect on their relationship with their clients (Reichelt & Skjerve, 2001). Open discussions in supervision were also thought to positively affect outcomes with clients (Ancis & Marshall, 2010; Burkard et al., 2009). This included an increased sensitivity to emotive clinical issues and greater confidence working with diverse clients. Conversely, participants who experienced a negative event within supervision described a detrimental impact on their clinical work. This typically related to feeling less available, or attentive, to clients (Burkard et al., 2009; Gray et al., 2001).

## Discussion

This meta-synthesis drew upon the experiences of 165 participants as reported in 15 studies. The analysis led to four key concepts, each of which was contributed to by at least nine of the studies. The included studies were of variable quality, when appraised using the

CASP (2013). However, each key concept was formed from studies at both the higher and lower end of the quality spectrum. This suggests no concept was of better "quality" than others. The results indicate supervision provides a number of different learning opportunities, but their success depends largely upon the supervisory relationship. Aspects of power appear to significantly influence experiences of supervision, the impact of which can be felt personally and professionally. The findings support existing literature which indicates these impacts from supervision can be experienced long-term (e.g. Milne et al., 2001; Wheeler & Richards, 2007).

Participants discussed a number of functions which supervision can fulfil, which often related to its role in teaching or learning. Developing supervisee competence and ensuring the quality of the client's service are described as the two key roles of supervision (Bernard & Goodyear, 2013; Falender & Shafranske 2004). This meta-synthesis suggests trainees are focussed on the former. Although there was discussion of supervision's impact on client work, participants typically referred to their own development. This may partly reflect the model of supervision, as some are client focussed whilst others concentrate on developing the supervisee's competence (Falender & Shafranske, 2004). Facilitating a trainee's professional development should in turn enhance therapy outcomes for clients (Ellis & Ladany, 1997). However participants' responses suggest the client may not always be central to a trainee's goals for supervision. This may be partly due to their awareness of being evaluated, and consequently focussing on their own performance; the evaluative element of supervision is suggested to be constantly present (Bernard & Goodyear, 2013; Briggs & Miller, 2005).

If supervisors and supervisees differ in their aims or focus of supervision, this could be experienced as unhelpful. Research has suggested supervisor-supervisee complementarity has a substantial influence on the supervisory working alliance (Chen & Bernstein, 2000). Qualitative studies have also suggested feelings of incompetence can arise from discrepancies

between the feedback expected and provided within supervision (De Stefano et al., 2007). This has several implications for supervisors. Supervisors should be supported to facilitate discussions with supervisees regarding hopes and expectations for supervision. They should also encourage trainees to seek routine feedback from service users (Lambert et al., 2001), to ensure the client remains within focus.

Participants' descriptions of helpful supervision often related to the supervisory alliance, including a supportive supervisor and feeling safe within the relationship. Although many of the included studies explored a particular supervisory focus or event, these aspects were considered globally beneficial. These findings are supported within the literature regarding "good" supervision (Cushway & Knibbs, 2004; Kilminster & Jolly, 2000; Wheeler, 2004). Participants' responses suggest experiences of supervision could be understood within models of attachment (e.g., Bowlby, 1969). Attachment theory proposes that children form an internal working model, based on their early interactions with caregivers (Dickson, Moberly, Marshall & Reilly, 2011). These models may be activated in response to stress, or within significant relationships. Pistole and Watkins (1995) discuss how supervisors can become a safe base, which enables supervisees to explore and develop in confidence. This safety is facilitated by qualities such as consistency, empathy and warmth, which were noted by participants in this study.

Supervisors should be encouraged to consider their supervisory relationships within the context of attachment theory. This includes attending to the attachment style of the supervisee, and how this may affect the supervisory relationship. For example, a supervisee with an anxious attachment style may appear "dependent and even "clingy"" (Bernard & Goodyear, 2013, p.92), which may in turn affect a supervisor's responses. Supervisors may also benefit from considering their own attachment style; White and Queener (2003) claimed

that supervisors' ability to form healthy attachments was predictive of the quality of the supervisory alliance.

The utility of a supervisor's approach may depend on a supervisee's perception of their supervisor's intentions. For example, some participants appreciated supervisors supporting them to discover their own answers (Johnston & Milne, 2012). Conversely, other participants felt their supervisor was "bating me" by not disclosing the answer (Reichelt & Skjerve, 2001, p. 34). This highlights the need for flexibility by supervisors. Some supervisors may begin to assume a particular approach is helpful, especially if they receive positive feedback. However, supervisors should continue to facilitate discussions regarding a supervisee's preferred way of working in supervision, and their response to sessions.

Power within supervision was referred to by the majority of included studies. Patel (2004) suggests power relations are central to supervision, and present within every aspect of the process. Whilst this can be experienced positively, participants often described it as central to negative events in supervision. Some violations of power described by participants raise concerns regarding supervisors' conduct, including "he screamed at me" (Wulf & Nelson, 2001, p. 130) and disclosing inappropriate information (Nelson & Friedlander, 2001). Participants described their coping strategies for difficult situations they experienced in supervision, such as these. Their responses, such as seeking external support, place the action or change with the supervisee. Whilst this may reflect the focus of the studies, it may indicate supervisees taking responsibility for resolving conflicts or negative events. This is potentially concerning, as this could lead to an increase in stress or anxiety for supervisees and consequently affect their clinical work. Where participants experienced conflict within supervision, they reported wishing their supervisor had addressed this in order to resolve it (Gray et al., 2001).

Participants' responses also highlight a need to consider the evaluation of supervisors themselves. The APS (2013) suggest "when members provide supervision, they must be competent to do so" (p.3) but do not provide guidance on measuring or ensuring this. The BPS (2013) requires training courses to have a "formal, documented audit process for clinical placements and supervision" (p. 31). However, no participants described providing feedback to their course on negative supervision events. Trainee therapists have previously indicated difficulties in being honest when evaluating their supervisors (O'Donovan, Dyck & Bain, 2001). This may be affected by numerous factors, including if the trainee wishes to work in the supervisor's service or speciality, and fearing the consequences of raising concerns. Training courses should consider options such as providing supervision for supervisors, and facilitating more opportunities for discussion/reflection on supervision within training. It may also be helpful to enable provision of anonymous feedback on supervision, or enabling discussions with an individual external to the course and without an evaluative role.

The majority of professional guidelines for therapist training courses recommend that supervisors access supervisor training (e.g., BPS, 2014). The findings within this study have several implications for these programmes, and emphasise the importance of providing such training. Supervisor training should include consideration of the supervisor qualities appreciated by participants within this study, and their contribution to a sense of safety in supervision. Training should also encourage supervisors to discuss the power differential within their relationship with trainees. Dennis and Aitken (2004) suggest using process models within supervision can aid consideration of different influences on supervision. This is supported by the APS (2013) and BPS (2008), who recommend supervisors take time to discuss the supervisory process with supervisees. Furthermore, training for supervisors should support supervisors in their provision of feedback, and how to ensure it is useful and appropriate.

In addition to providing supervisor training, it may also be beneficial to facilitate supervisee training. Green (2004) suggests a role for incorporating this into therapy training programmes, which would include skills such as delivering thorough clinical reports. This could also address aspects such as the different roles of supervision, coping strategies for difficult situations and possible ways to deliver and receive feedback. Training for both supervisors and supervisees should emphasise the importance of creating a supervision contract at the placement outset, as it can address a number of aspects highlighted by participants (Driscoll, 2000).

**Limitations**

The studies included within this meta-synthesis drew upon the experience of trainee therapists from various theoretical orientations and therapeutic backgrounds. Although each participant was training to deliver a talking therapy, there may be important differences between these groups which affect their experiences of supervision. Supervisions which adopt a particular psychological approach can differ significantly in their structure, and consequently comparison may not be entirely possible. However, the key goals of supervision remain the same, and therefore it is of value to note the "meta-perspective:" the aspects of supervision which are valued regardless of model or orientation.

Table 2 and Table 3 demonstrate demographic information of the included studies and their participants. It is clear there is a gender bias, with many more females participating. This is likely due to the gender inequality of therapists generally; the American Psychological Association suggest men represent only 24% of new psychology doctorates (Willyard, 2011), whilst in the UK 17% of applications for clinical psychology training in 2013 were male (Clearing House for Postgraduate Courses in Clinical Psychology, 2013). Nine of the studies took place within the USA, and a further three in the UK. Consequently, the results are not generalizable to all trainee therapists, particularly those outside the Western culture. The

understanding and interpretation of mental illness varies widely across different cultures (Abdullah, 2011; Rao, Feinglass & Corrigan, 2007). It follows that the aims and expectations for therapy, and therefore supervision, may also differ.

As stated previously, a number of the included studies focussed on a particular aspect of supervision, such as negative events or power. Some studies also attended to specific cultural aspects, such as sexual identity or cross-cultural supervisors. This may have led some topics presented within the findings to be over-weighted. However, these aspects often related to wider issues discussed across papers, such as discussion of differences between supervisor and supervisee.

**Future Research**

A number of aspects highlighted by this meta-synthesis could warrant further research. This includes exploring the extent to which trainee therapists consider supervision as addressing their own competence, or the client's experience.

Substantial emphasis was placed on the process of learning together, which could arise from exploring differences between supervisor and supervisee. This implies supervision can also contribute to the professional development of the supervisor. However there is a lack of research regarding the impact of providing supervision on the supervisor themselves, which future research could work to address.

Considering the suggestion from participants that trainee therapists may not voice any difficulties they experience with supervisors, research into how trainees manage negative supervisory experiences could be of use. In addition, further exploration of how to support supervisees in addressing these experiences, including possible ways of evaluating supervisors, may be beneficial. Finally, research could examine the implementation and evaluation of Green's (2004) proposal to include supervision training for supervisees.

## Conclusion

Supervision is a valuable resource for trainee therapists, which promotes both personal and professional development. It can also provide support during the challenges of training, and ensure clients receive the best possible care. However the findings suggest supervision also has the potential to cause trainees to experience distress and self-doubt. Fear of negative evaluation can affect trainees' management of these events. Recognition and exploration of the power differential within supervision is important in strengthening the supervisory relationship, which in turn maximises the opportunities for trainees to learn and develop.

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Table 1

*Quality appraisal using the CASP (2013)*

| Studies | Statement of aims | Appropriate for qualitative research | Appropriate design | Sampling | Data collection | Reflexivity | Ethical issues | Data analysis | Findings | Value of the research | Final score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Ancis & Marshall 2010 | 3 – clear rationale and statement of aims | 3 – explanation of why qualitative methodology chosen | 2 – some decisions justified but not specific method (GT) | 2 – some explanation of sample but little on strategy | 3 – clear explanation of data collection | 1 – brief mention of assumptions but not how managed or impact | 2 – no explicit ethical considerations but measures taken to ensure confidentiality | 2 – description of process but not clear how themes arrived at | 2 – findings explicit, discuss credibility but no discussion of alternative interpretation | 3 – discuss implications, recommendations and future research | 23 |
| Bottrill, Pistrang, Barker & Worrell 2010 | 3 – clear rationale and statement of aims | 3 – clear explanation of why methodology chosen | 3 – clear rationale for specific method | 3 – clear how and why participants recruited | 3 – data collection fully detailed | 2 – role and position of each author described and potential influence | 2 – ethical approval not detailed but measures described to ensure ethical standards | 3 – in-depth description of analysis process | 2 – findings and credibility discussed but no discussion of exploring contradictory findings | 2 – discuss implications but not future research or other utility of findings | 26 |
| Burkard, Knox, Hess & Schultz 2009 | 3 – clear rationale and statement of aims | 2 – limited explanation of why methodology chosen | 2 – some rationale for specific method presented | 3 – clear how and why participants recruited | 3 – data collection fully detailed (other than location) | 2 – assumptions of each author discussed but not experience | 2 – ethical approval not detailed but ethical standards such as informed consent described | 2 – some description of process but no demonstration | 3 – explicit findings and discuss cross-analysis and checking for accuracy | 3 – full discussion of implications, future research and new knowledge | 25 |
| De Stefano, D'Iuso, Blake Fitzpatrick, Drapeau & 1hamodraka 2007 | 3 – clear rationale and statement of aims | 2 – limited explanation of why methodology chosen | 1 – no justification for specific method presented | 2 – explanation of sample but little on strategy | 3 – data collection fully detailed | 2 – limited discussion of team biases | 1 – ethical approval not detailed, nor aspects such as consent | 2 – some description of process but no demonstration | 2 – findings explicit, implicit discussion of credibility, no exploring contradictory findings | 3 – discussion of implications, future research and recommendations | 21 |
| Folkes-Skinner, Elliott & Wheeler | 3 – clear rationale and statement | 2 – appropriate methodology but not discussed | 1 – no justification for research design | 2 – some explanation of participant | 3 – clear explanation of topic guide, | 2 – role and assumptions of each author detailed | 3 – full details of ethical approval and standards given | 2 – analysis described but example of interpretation | 2 – findings related to aims but no discussion of credibility | 2 – some new knowledge highlighted | 22 |

| Studies | Statement of aims | Appropriate for qualitative research | Appropriate design | Sampling | Data collection | Reflexivity | Ethical issues | Data analysis | Findings | Value of the research | Final score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2010 | of aims | | provided | but no detail of process | interviews and process | | | not provided | | | |
| Gray, Ladany, Walker & Ancis 2001 | 3 – clear rationale and statement of aims | 3 – explanation of why qualitative methodology applied | 1 – no real justification for specific method provided | 3 – full explanation of recruitment process | 3 – clear details of data collection | 3 – assumptions and experiences of each author presented, and how managed during research | 1 – ethical approval not detailed, no discussion of consent or confidentiality except pseudonym | 3 – in-depth description of analysis process | 3 – findings explicit, discuss cross-analysis and checking for accurate representation of data | 3 – full discussion of implications, future research and new knowledge | 26 |
| Johnston & Milne 2012 | 3 – clear rationale and statement of aims | 2 – appropriate methodology but not discussed | 2 – brief justification for specific method | 2 – limited details of sampling process provided | 2 – limited description of data collection | 2 – epistemology briefly described | 2 – ethical approval detailed and some details of methods | 2 – analysis described but no examples provided | 2 – findings clearly presented but no discussion of credibility | 2 – future research recommended, some but limited implications discussed | 21 |
| Marshall & Wieling 2003 | 3 – clear statement of aims of study | 3 – justification for using qualitative methodology provided | 1 – no justification presented for specific method | 2 – limited description of sampling process | 2 – description of data collection process but not questions used | 2 – some description of authors' experiences but not impact on research | 2 – no ethical approval detailed but standards such as consent described | 2 – process detailed but no examples provided | 3 – findings clearly presented and trustworthiness discussed | 2 – lengthy discussion of findings but limited mention of future research or recommendations | 22 |
| Murphy & Wright 2005 | 2 – brief explanation of rationale and aims | 2 – appropriate methodology but not discussed | 2 – brief justification for specific method | 2 – some description of process but not fully detailed | 2 – some description of data collection | 3 – assumptions and experience of authors detailed and how managed | 1 – no ethical approval or standards such as informed consent or confidentiality described | 2 – process detailed but no examples of how themes developed | 3 – findings explicit and full discussion of credibility | 2 – implications and value discussed but limited exploration of future research | 21 |
| Nelson & Friedlander 2001 | 2 – brief explanation of rationale and aims | 2 – appropriate methodology but not discussed | 1 – no justification presented for specific method | 2 – limited description of sampling process | 3 – full description of data collection | 2 – assumptions and experiences of authors | 2 – no ethical approval detailed but standards such as consent and | 2 – process detailed but no examples of how themes developed | 3 – findings explicit and some discussion of credibility | 3 – implications, value and future research all discussed | 22 |

| Studies | Statement of aims | Appropriate for qualitative research | Appropriate design | Sampling | Data collection | Reflexivity | Ethical issues | Data analysis | Findings | Value of the research | Final score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | detailed but not how managed | confidentiality described | | | | |
| Perry 2012 | 3 – clear rationale and aim of study | 2 – appropriate methodology but not discussed | 1 – no justification presented for specific method | 2 – limited description of sampling process | 3 – full description of data collection | 1 – very limited attention to reflexivity | 2 – no ethical approval detailed but standards such as confidentiality described | 1 – very limited description of data analysis | 2 – findings mostly clear, some discussion of trustworthiness | 2 – some discussion of relevance of findings and implications | 19 |
| Reichelt & Skjerve 2001 | 3 – clear rationale and aim of study | 3 – detailed why qualitative methodology appropriate | 1 – no justification presented for specific method | 1 – no description of sampling process | 3 – full description of data collection | 2 – limited description of authors' stances | 1 – no ethical approval detailed or standards such as consent | 2 – some detail of process but no examples provided | 2 – findings presented clearly and limited discussion of credibility | 2 – some discussion of relevance of findings and implications | 20 |
| Rhodes, Nge, Wallis & Hunt 2011 | 2 – brief explanation of aim of study | 2 – appropriate methodology but not discussed | 1 – no justification presented for specific method | 1 – no description of sampling process (except pool) | 2 – limited description of data collection | 2 – limited description of authors' stances | 1 – no ethical approval detailed or standards such as consent | 2 – some detail of process provided | 2 – findings presented clearly and some discussion of reliability | 2 – limited discussion of relevance of findings and future research | 17 |
| Worthen & McNeill 1996 | 2 – brief explanation of aim of study | 2 – appropriate methodology but not discussed | 1 – no justification presented for specific method | 1 – no description of sampling process (except pool) | 3 – data collection fully described | 2 – authors' assumptions and experience detailed but not how managed | 2 – no ethical approval detailed but standards such as consent discussed | 3 – good detail of analysis process | 2 – findings presented clearly, some discussion of credibility | 2 – discussion of relevance of findings, limited attention to future research or implications | 20 |
| Wulf & Nelson 2001 | 3 – clear rationale and aim of study presented | 2 – appropriate methodology but not discussed | 1 – no justification presented for specific method | 3 – recruitment process fully described | 2 – some description of process but not interview schedule | 1 – no attention to reflexivity | 2 – no ethical approval detailed but standards such as consent discussed | 2 – good description of process but no examples provided | 2 – findings presented clearly but little attention to credibility | 3 – clear discussion of relevance, implications and future research | 21 |

Table 2

*Demographic Information of Participants Included within the Meta-synthesis*

| Study | Sample | Age (years) | Ethnicity | Gender | Location |
|---|---|---|---|---|---|
| Ancis & Marshall 2010 | 4 doctorate trainees (2x clinical, 2x counselling) | Range = 27-41 | 3 European American<br>1 Asian American | 2 female<br>2 male | USA |
| Bottrill, Pistrang, Barker & Worrell 2010 | 14 clinical psychology trainees | Range = 26-32 | 12 White<br>1 Mixed race<br>1 Asian British | 10 female<br>4 male | UK |
| Burkard, Knox, Hess & Schultz 2009 | 17 professional psychology trainees (6x clinical psychology, 1x counsellor education, 10x counselling psychology) | Range = 24-49<br>Mean = 34.41<br>SD = 7.68 | 16 European American<br>1 Native American | 7 female<br>10 male | USA |
| De Stefano, D'Iuso, Blake Fitzpatrick, Drapeau & Chamodraka 2007 | 8 counselling psychology trainees | Range = 23-28 | 8 Anglo-European | 5 female<br>3 male | Canada |
| Folkes-Skinner, Elliott & Wheeler 2010 | 1 trainee counsellor | 50 | Not stated | 1 female | UK |
| Gray, Ladany, Walker & Ancis 2001 | 13 psychotherapy trainees | Range = 23-29<br>Mean = 25.92<br>SD = 2.10 | 12 White<br>1 person of colour | 10 female<br>3 male | USA |
| Johnston & Milne 2012 | 7 trainee clinical | Mean = 26.71 | Not stated | 7 female | UK |

| Study | Sample | Age (years) | Ethnicity | Gender | Location |
|---|---|---|---|---|---|
| | psychologists | SD = 2.06 | | | |
| Marshall & Wieling 2003 | 12 marriage and family therapy trainees | Mean = 32<br>Range = 24-49 | 8 Anglo-American<br>1 Latino/Hispanic<br>1 African American/Black<br>2 Other | 8 female<br>4 male | USA |
| Murphy & Wright 2005 | 11 family therapy trainees (masters & doctoral) | Range = 23-38 | 11 Caucasian | 8 female<br>3 male | USA |
| Nelson & Friedlander 2001 | 13 psychology trainees (masters and doctoral) | Range = 29-52<br>Mean = 37<br>SD = 7 | 11 White<br>1 Chicano/a<br>1 Asian American | 9 female<br>4 male | USA |
| Perry 2012 | 9 trainees of online graduate clinical training program | Range = 26-61<br>Mean = 34.8 | Not stated | 5 female<br>4 male | USA |
| Reichelt & Skjerve 2001 | 18 psychology interns | Not stated | Not stated | Not stated | Norway |
| Rhodes, Nge, Wallis & Hunt 2011 | 24 family therapy trainees | Range = 23-51<br>Mean = 27.4 | Not stated | 21 female<br>3 male | Australia |
| Worthen & McNeill 1996 | 8 counselling trainees | Range = 23-54 | 8 European-American | 4 female<br>4 male | USA |
| Wulf & Nelson 2001 | 6 licensed psychologists | Range = 29-33 | Not stated | 3 female<br>3 male | USA |

Table 3

*Descriptive Information of the Studies Included within the Meta-synthesis*

| Study | Focus | Sampling | Data collection | Data analysis |
|---|---|---|---|---|
| Ancis & Marshall 2010 | Culturally competent supervision, multicultural framework | Not stated | Semi-structured interview | Grounded theory |
| Bottrill, Pistrang, Barker & Worrell 2010 | Use of therapist self-disclosure, including supervision on the issue | Circulated information via email through training programmes | Semi-structured interview | Interpretive phenomenological analysis |
| Burkard, Knox, Hess & Schultz 2009 | Lesbian, gay and bi-sexual experiences of supervision | Invitation posted online via listserv | Semi-structured interview | Consensual qualitative research |
| De Stefano, D'Iuso, Blake Fitzpatrick, Drapeau & Chamodraka 2007 | Supervision after experiencing an impasse in clinical work | Not described | Semi-structured interview | Consensual qualitative research |
| Folkes-Skinner, Elliott & Wheeler 2010 | Experience at start of training | Interested students added details to list in business meeting; sample selected by convenience | Single case study - 3x semi-structured interviews (beginning, middle and end of first term) | Interpretive phenomenological analysis |
| Gray, Ladany, Walker & | Counterproductive events in | Information packets | Semi-structured | Consensual |

| Study | Focus | Sampling | Data collection | Data analysis |
|---|---|---|---|---|
| Ancis 2001 | supervision | distributed to training programmes and personal contacts | interview | qualitative research |
| Johnston & Milne 2012 | How learn during supervision | Iterative approach, purposively sampled initially then theoretical sampling employed | Semi-structured interview | Grounded theory |
| Marshall & Wieling 2003 | Cross-cultural supervision | Flyers and follow-up calls | 3x focus group | Developmental research sequence |
| Murphy & Wright 2005 | Perspectives of power use in supervision | Contacted eligible participants by email | Semi-structured interview | Grounded theory |
| Nelson & Friedlander 2001 | Conflictual supervisory relationships | Solicited through electronic mailing lists and word of mouth | Semi-structured interview | Discourse analysis |
| Perry 2012 | Professional identity and online supervision | Contacted eligible participants by email | Telephone interview | Phenomenological |
| Reichelt & Skjerve 2001 | Supervision of inexperienced therapists | Not stated | Semi-structured interview using Interpersonal Process Recall after listening to | Grounded theory |

| Study | Focus | Sampling | Data collection | Data analysis |
|---|---|---|---|---|
| | | | tape of supervision | |
| Rhodes, Nge, Wallis & Hunt 2011 | Exploring personal effects of family therapy training – inc. themes regarding supervision | Not stated | Semi-structured interview | Grounded theory |
| Worthen & McNeill 1996 | Good supervision events | 'Solicited and selected participants' from sites | Semi-structured interview | Consensual qualitative research?? |
| Wulf & Nelson 2001 | Recollections of internship supervision | Recruited via telephone message from list of psychologists from Dept of Health | Semi-structured interview | Analyse meaning units then thematic content |

Table 4

*A table to show the themes and interpretations presented within the included studies which led to the key concept of 'power in supervision'*

| Themes presented by authors | Key concept |
|---|---|
| Negative supervision after impasse – unsafe, critical | |
| Stressful evaluations and expectations in supervision | |
| Characteristics of impasse in supervision – power struggle | |
| Perceptions of supervisor reactions to impasse in supervision | |
| Supervisee feeling powerless in supervision | |
| LGB non-affirming event – oppression/bias | |
| Demonstrates awareness of clinical significance of racism and oppression | |
| Encourages consideration of cultural assumptions | |
| Initiates and engages in discussion about power struggles | |
| Counterproductive event – dismissive of trainee, denied request | |
| Supervisor's misuse of power | |
| Supervisee's misuse of power | |
| Supervisees as consumers in supervision | |
| Supervisee-peer power in supervision | Power dynamics in supervision |
| Supervisors inappropriately meeting own needs | |
| Violation of confidentiality in supervision | |
| Making evaluations in supervision | |
| Direct and indirect discussions of power in supervision | |
| Supervisees withholding information in supervision | |
| Sharing feedback with supervisors on supervision | |
| Promoting an atmosphere of safety in supervision (personal power) | |
| Disclosure of reaction to counterproductive event | |
| What supervisor could have done to facilitate discussion of nonaffirming event | |
| Reasons for not discussing LGB nonaffirming event (fear) | |
| Effect of LGB nonaffirming event on supervision relationship (unsafe) | |
| Facilitates a safe and open supervisory climate, can be vulnerable and take risks | |

Table 5

*Description of which studies contributed to each of the key concepts, which are: 1: Supervision as a learning opportunity, 2: Supervisory relationship, 3: Power in supervision, 4: Impact of supervision*

| Papers | Concepts | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| Ancis & Marshall 2010 | x | x | x | x |
| Bottrill, Pistrang, Barker & Worrell 2010 | x | x | x | |
| Burkard, Knox, Hess & Schultz 2009 | x | x | x | x |
| De Stefano, D'Iuso, Blake Fitzpatrick, Drapeau & 1hamodraka 2007 | x | | x | |
| Folkes-Skinner, Elliott & Wheeler 2010 | x | | | x |
| Gray, Ladany, Walker & Ancis 2001 | x | x | x | x |
| Johnston & Milne 2012 | x | x | x | |
| Marshall & Wieling 2003 | | x | | |
| Murphy & Wright 2005 | x | x | x | |
| Nelson & Friedlander 2001 | | x | x | x |
| Perry 2012 | x | | | |
| Reichelt & Skjerve 2001 | x | x | | x |
| Rhodes, Nge, Wallis & Hunt 2011 | x | | | x |
| Worthen & McNeill 1996 | x | x | | x |
| Wulf & Nelson 2001 | x | x | x | x |

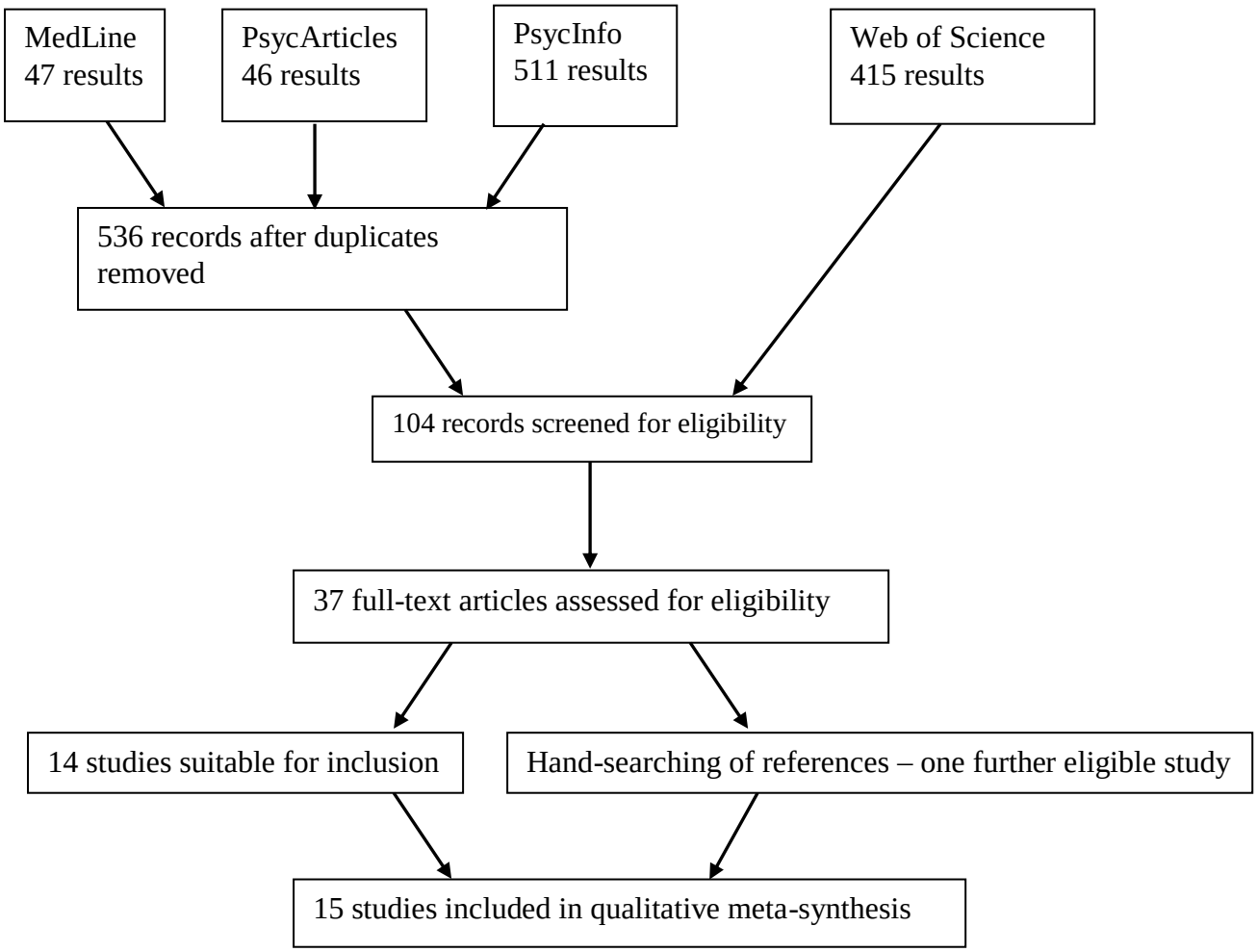


*Figure 1*. A Flowchart to Demonstrate Study Selection

# Appendices

## Appendix A: Author Guidelines for Psychology and Psychotherapy: Theory Research and Practice

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

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- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/paptrap/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

5. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

• Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org).

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Section Two: Research Paper

# Clinical Psychologists' Experiences of Accessing Personal Therapy during Training: A Narrative Analysis

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**Abstract**

Personal therapy can support therapists in their personal and professional development. Little is known about the experiences of trainee clinical psychologists who utilise therapy whilst training. Ten clinical psychologists were recruited, and asked to share their story of accessing personal therapy during training. Data were analysed using narrative analysis, which led to the development of four chapters. Chapter one explores the context of being a trainee clinical psychologist whilst experiencing therapy, including stressors encountered during training. In chapter two, participants discuss the stigma they felt in accessing personal therapy. Through chapter three, participants describe the journey of therapy itself, including difficult emotions they experienced and events such as "the ending." Finally, chapter four details some personal and professional impacts of their therapy journey. The clinical and professional implications of these findings are discussed, in addition to recommendations for future research.

# Clinical Psychologists' Experiences of Accessing Personal Therapy during Training: A Narrative Analysis

Personal therapy for mental health therapists is cited as an important process which facilitates both personal and professional development (Sheikh, Milne, & MacGregor, 2007). This is not a new proposition, with Freud (1964) emphasising its importance 50 years ago. However this view is not universal. Whilst some claim personal therapy supplements therapists' learning and development in a unique way (Norcross, 2005), others suggest it can have negative impacts (Atkinson, 2006).

For some therapists, accessing personal therapy during training is mandatory. The Division of Counselling Psychology requires trainees in the UK to undertake 40 hours of personal therapy during training (British Psychological Society [BPS], 2006). Similarly, most trainee psychotherapists are required to experience therapy (Rizq, 2011). The British Association for Counselling and Psychotherapy previously required trainees to access personal therapy, but replaced this in 2005 with a requirement to access experiences that heighten self-awareness (von Haenisch, 2011). Conversely, clinical psychology trainees are not required to undertake personal therapy. These differences highlight the lack of clarity in whether it is a useful tool for therapists in training.

This introduction will review benefits which may arise from personal therapy, such as emotional support, developing self-awareness and learning opportunities. It will also consider potential negative impacts from therapy, and whether current empirical evidence suggests any detectable effect on client outcomes. Finally, it will review the use of personal therapy by clinical psychology trainees. Throughout, the term "personal therapy" refers to mental health therapists accessing psychological treatment (Geller, Norcross, & Orlinsky,

2005). This can be voluntary or mandatory, and provided by clinicians from a range of theoretical orientations (Kumari, 2011).

## Effects of Personal Therapy

Personal therapy is advocated by many psychotherapeutic approaches for both training and practising therapists (Rake, 2009). In a systematic review, Orlinsky, Norcross, Ronnestad and Wiseman (2005) found 88% of 3,629 therapists from 13 countries reported positive outcomes from personal therapy. Additionally, 75% of 3,868 clinicians claimed it strongly influenced their professional development. These influences/benefits have been previously grouped into: Increased emotional and mental functioning; understanding of personal dynamics, values and conflict; alleviating emotional stresses; socialisation to therapy; experiencing the client role; and observation of therapeutic skills (Grimmer & Tribe, 2001). However, some evidence contradicts these findings, such as therapy potentially causing stress (e.g., Moller, Timms & Alilovic, 2009). The proposed outcomes from personal therapy can be broadly grouped into: Emotional support, including coping with stress; self-awareness; and professional development.

### Emotional support.

Personal therapy can support therapists in managing personal and professional stressors (Daw & Joseph, 2007; Norcross, Dryden & DeMichele, 1992). Therapist training courses can be stressful (Timms, 2010), balancing clinical placements, research projects and teaching. Attending to self-care can reduce the risk of stress-related absences. Holzman, Searight and Hughes (1996) surveyed 1,018 clinical psychology trainees, and found 38% cited depression as motivation for seeking therapy, and 32% relationship difficulties. This suggests a substantial proportion of trainee therapists accessing therapy are seeking emotional support. A more recent survey conducted by Bike, Norcross and Schatz (2009) indicated that

92% of 727 psychotherapists reported improvement in emotion-relief from personal therapy. However, this was based on one item; therefore its significance may be limited.

Trainee therapists have indicated their emotions can impact on performance, and therapy can support them through the pressures of training (Moller et al., 2009). This may be particularly salient when trainees encounter distressing client work. Whilst supervision would hopefully provide support in these instances, this may depend on the supervisory relationship (Bernard & Goodyear, 2013). Personal therapy may provide additional, or unique, support in allowing therapists a space to process emotions. One consequence of this can be realising one "could be themselves and yet still be a good therapist" (Bellows, 2007, p. 214). This may be particularly important whilst training, where an individual's competencies are subject to evaluation.

Whilst it seems intuitive to assume personal therapy provides emotional support to therapists, some research suggests it may create psychological distress. Macaskill and Macaskill (1992) conducted a survey and found 38% of trainees indicated negative effects of accessing therapy, although no trainee reported only negative outcomes. Personal therapy may also "open a can of worms" (Moller et al., 2009, p. 379), resulting in emotional instability whilst dealing with difficulties. These experiences can be unhelpful both personally and professionally; trainees reported struggling to be "emotionally available" for clients whilst preoccupied with their own issues (Kumari, 2011, p. 226).

In their review of the literature, Macran and Shapiro (1998) claimed "despite its positive qualities personal therapy imposes a major burden, particularly for therapists undergoing training" (p. 16). This included relationship difficulties, time and financial restraints, and preoccupation with personal conflicts. Rake and Paley (2009) also suggest detrimental aspects of therapy can be destabilising. These, and other, negative effects may be under-reported within the literature; 22% of trainees reported psychological distress as an

outcome of their personal therapy, but considered this part of the process (Macaskill & Macaskill, 1992). This does not, however, indicate whether the distress they experienced was considered worthwhile for any gains achieved.

**Self-awareness.**

Some authors emphasise the importance of trainee therapists gaining self-awareness, in order to support others achieving the same (Norcross, 2005). A heightened self-awareness allows therapists to distinguish between emotional reactions of themselves and a client, and develops a clinician's resilience (Kumari, 2011; Oteiza, 2010). Research studies suggest a link between personal therapy and increased self-awareness (Macaskill & Macaskill, 1992; Macran & Shapiro, 1998). This includes acknowledging personal triggers and processing personal issues (Ivey & Waldeck, 2013; Moller et al., 2009). Rake and Paley (2009) conducted interviews with qualified therapists, who suggested increased self-awareness also improved their tolerance of clients' emotional reactions. Conversely, personal therapy may lead to trainees becoming preoccupied with their own experiences, rather than increasing self-awareness (Ivey & Waldeck, 2013). This may in turn negatively impact on client work. Consequently, personal therapy may not offer the same benefits to all trainee therapists.

The potential for difficult emotional issues to arise has been cited by Thomas and Dryden (1991) as one reason why personal therapy should not be mandatory. They emphasise the importance of readiness and choice in order for therapy to be effective. They also argue trainees who find therapy unhelpful may continue out of obligation to their course. Some participants of qualitative studies have expressed frustration and anger at the mandatory aspect of their therapy (Rizq & Target, 2010; von Haenisch, 2011). The majority of research regarding personal therapy has been conducted with samples required to access therapy. Therefore, it's unclear how much this aspect may affect participants' responses regarding the experience and efficacy of therapy overall.

### Professional development.

Several studies suggest accessing personal therapy provides valuable experiential learning for trainee therapists, which then impacts on their clinical practice (Grimmer & Tribe, 2001; Ivey & Waldeck, 2013; Kumari, 2011). This includes socialisation to different approaches, and modelling opportunities (Murphy, 2005; Norcross & Guy, 2007; Rake & Paley, 2009). Qualitative research conducted by Moller et al. (2009) suggested experiencing the client role and seeing therapy "in action" (p. 376) was particularly helpful. However, some of the reported learning may have occurred through supervision and other opportunities, rather than being specific to therapy. Other skills reportedly gained through personal therapy include the use of boundaries and intuition (von Haenisch, 2011).

Trainee clinical psychologists interviewed by Ivey and Waldeck (2013) in South Africa also described the value of personal therapy, as "you need to know how damn hard it is sometimes to be a patient" (p. 3). Macaskill (1999) suggests this could be accessed through peer counselling or role play within training, but qualitative studies indicate being a client provides a unique opportunity in developing empathy (Moller et al., 2009). However, this can lead to trainees assuming what worked for oneself will work for clients (Kumari, 2011).

## Impact on Therapy Outcomes

Quantitative data have supported the positive impact of personal therapy on the therapeutic alliance, including therapist confidence and client commitment (Gold & Hilsenroth, 2009). Strupp (1973) conducted a study whereby participants responded to a filmed therapy session, which suggested therapists who underwent personal therapy displayed greater empathy. However, the ecological validity of this method is questionable considering the artificial scenario. One study demonstrated significantly lower premature termination rates for therapists who had received personal therapy (Greenspan & Kulish,

1985), however other studies have suggested no significant difference (Macran & Shapiro, 1998). Two reviews of the literature also suggested little empirical evidence of positive effects on therapy outcomes, such as therapist and client improvement ratings (Clark, 1986; Macran & Shapiro, 1998).

Whilst this could suggest positive impacts of personal therapy are not translated into clinical outcomes, the majority of benefits proposed have not been quantitatively explored (Macaskill, 1999). In addition, much of the published literature has been conducted without "large samples, controls, random assignment to personal therapy or nontherapy, and prospective designs" (Norcross & Guy, 2007, p. 172). Future research which addresses these shortfalls would add to our understanding, although caution is needed as "the quantification of experience on Likert scales seems far too impoverished to describe the experience of personal therapy" (Wiseman & Shefler, 2001, p.131).

Bellows (2007) suggests a chain effect of how personal therapy may impact on client outcomes. Psychotherapists suggested accepting their fallibility reduces perfectionist expectations, and promotes a more realistic self. Clients then witness and internalise the therapist's modelled self-acceptance and self-respect. Wiseman and Shefler (2001) suggest the personal and professional aspects of a therapist are not easily separated, particularly considering the use of self-awareness as a therapeutic tool. Consequently, any personal benefits from personal therapy are likely to translate into positive clinical effects.

**Personal Therapy for Clinical Psychology Trainees**

The majority of research regarding personal therapy has been conducted with counselling psychologists or psychotherapists, with little involving clinical psychology trainees as participants (Timms, 2010). This may be due to it not being a mandatory requirement for the latter group. Despite this, a number of clinical psychology trainees choose to access therapy. Nel, Pezzolesi and Stott (2012) surveyed 357 clinical psychologists

within the UK; 26% accessed personal therapy during training. 88% of those rated it as important in their development. Similarly, trainees in Australia described a number of benefits, suggesting training and therapy "inform and enrich each other" (Ivey & Waldeck, 2013, p. 7). However, some trainees have described sometimes feeling worse during the process (Timms, 2010). These negative experiences related to therapy being "hard work" (p. 37) but contributed positively to the overall process.

The lack of agreement on the utility of personal therapy for trainee therapists is reflected in British clinical psychology training programmes. Some courses are rated by trainees as funding or encouraging therapy, whilst others are suggested to do neither (BPS, 2013). Although research regarding personal therapy is likely to be applicable to clinical psychology, there are significant differences in the training programmes. Within the UK, clinical psychology trainees are salaried, whereas psychotherapy and counselling trainees typically self-fund their training and therapy (Moller et al., 2009). Financial burden has been cited as one factor negatively impacting on the experience (Kumari, 2011) but this may be less so for clinical psychology trainees. In addition, the fact that personal therapy is not mandatory during clinical psychology training may affect the motivations, expectations and experiences of those trainees who access it.

**Aims and Rationale**

Research suggests the majority of therapists who access personal therapy during their training find it beneficial; however there is a lack of information regarding the journey of undertaking personal therapy for trainee clinical psychologists. It is also unclear to what extent personal therapy is encouraged, or supported, for this professional group.

Although there have been qualitative studies regarding this topic with other groups of therapists, there is a paucity of narrative research. Squire (2008) describes how narratives, or stories, are how humans make sense of their experiences. Telling stories is suggested to

allow individuals to process events they have experienced, and draw meaning from them (Wertz et al., 2011). This study sought to explore participants' experiences of accessing personal therapy during training, including its impact on their personal and professional development. Employing a narrative approach enabled participants to share their stories, and consider how they viewed and understood their experiences (Josselson, 2011). It also allowed exploration of the cultural and social contexts of participants' stories (Patton, 2002). Unlike some other methods, narrative analysis also preserves accounts given by participants, rather than fragmenting them without context (Riessman, 2008).

## Method

### Design

A qualitative design was employed to enable an in-depth exploration of clinical psychologists' experiences. Narrative analysis was considered the most appropriate approach to achieve the study aims. Narrative psychology explores how individuals make meaning of their experiences and the world (Murray, 2008), and posits that narration is quintessentially human (Byatt, 2000). Riessman (2008) suggests using narrative methods allows participants to tell their stories, through which identity is constructed. Stories are created within a social world, influenced by both the hearer's, and the teller's own social, cultural and political situation (Murray, 2008). This study sought to give voice to individuals' stories, and the way in which they understood and assimilated their experiences of personal therapy.

### Ethical Considerations

This study was reviewed and given ethical approval by Lancaster University (see Ethics Section). In addition, local NHS Research and Development guidelines were adhered to where appropriate, as some participants requested to conduct the interview during work time, or on work premises.

Although it was not anticipated participants would find the interview distressing, the topic was recognised as potentially emotive. Consequently a debrief sheet with information of support services was provided for each participant.

**Sampling and Participants**

The recruitment process is outlined in Figure 1. All clinical training programmes within the UK were emailed, asking if they would circulate the study information to past trainees. Thirty three courses were contacted, including one which had recently closed; 11 replied yes, and 8 replied no. The majority of 'no' responses were due to course policy or not maintaining contact details.

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Figure 1 around here

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The courses who replied 'yes' were asked to forward the information and interest form to qualified individuals who began training in 2002 or later. The BPS (2002) added 'Personal Professional Development' as a core competency of clinical psychology training in 2002, therefore it was considered more likely personal therapy was encouraged or facilitated after this date. Sixteen expressions of interest were received. Of those individuals who expressed an interest, six resided in Northern Ireland. Due to logistical difficulties, they were thanked for their interest but not interviewed. The remaining 10 individuals were contacted to arrange a convenient time and location for the interview. Further methods of recruitment were not utilised as the target number of participants was reached.

Interviews were conducted August - October 2013. Information regarding participants and their experiences of personal therapy is presented in Table 1.

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Table 1 around here

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**Interview Procedures**

The interview schedule began with an open question, to increase the likelihood of narrativisation (Riessman, 1993) (see Ethics Section). Additional prompts were included, to be used flexibly (Howitt, 2010). The aim of a narrative interview is to produce detailed accounts (Riessman, 2008); consequently prompts such as "can you tell me more about that" were employed to encourage expansion.

Before each interview, the participant was given the information sheet and any questions were answered, before the participant signed consent. Each interview occurred at the participant's home or workplace. Interviews were recorded using an Olympus voice recorder. On completion, the debrief sheet was provided and any questions were answered.

The interviews ranged in length from 52 – 85 minutes. Two were listened to by at least one supervisor, allowing discussions with the researcher regarding development of interviewing style, including narratives which could be explored further.

**Reflexivity Statement**

It is important to note the epistemological stance from which this research was conducted (Willig, 2013). The researcher believes there is no objective "truth" to obtain, and the data cannot be fully separated from the author's beliefs and interpretations (Coffey, 1999; Sword, 1999). Similarly, a participant's perception of themselves and their experiences is fluid. Telling stories carries a significant social component, as there is both a teller and a hearer; they are never told the same twice (Squire, 2008). It is important to consider the

context in which narratives are uttered, including possible motives for constructing them in a given way (Josselson, 2011). The researcher's position as a trainee clinical psychologist may have affected participants' construction of their narratives (see Critical Appraisal).

It is also important to acknowledge the researcher's own position and assumptions which may influence the study. The author believes narrative analysis values the structure, tone and context of participants' stories, where other methods can fracture them and lose meaning (Riessman, 1998). The role of research is seen as allowing these stories to be told and heard, with the goal of creating change at a personal or wider level. Accordingly, the author considers the dissemination of research to be important.

As a trainee clinical psychologist who accessed personal therapy during training, a reflective diary was kept by the researcher to acknowledge any assumptions. This contributed to the analysis, by reflecting on the tone of each interview. Discussions were held with supervisors when strong reactions were experienced, and regular meetings with other narrative researchers were attended. These actions allowed the researcher to be guided by participants in both interviews and analysis, but the researcher's subjectivity cannot be fully separated from the data (Lyons, 2007).

**Data Analysis**

There is no definitive guide to conducting narrative analysis (Smith & Sparkes, 2006). The data analysis drew upon several narrative methods and frameworks, such as Crossley (2000), Murray (2008), Riessman (1993; 2008), and Weatherhead (2011). Initially, interview transcripts were read repeatedly to gain familiarity. Each transcript was then separated into narrative segments (Weatherhead, 2011). Several aspects were explored and noted within each segment: Narrative tone; imagery; characters; pace; and key themes presented (Crossley, 2000) (see Appendix A). A summary story was written for each participant, to help ensure the final analysis captured their key events and themes.

Each transcript was examined for common themes, characters and stories. This led to the development of shared plots, which represented the narratives across the 10 transcripts. These were compared against the summary stories, to ensure no key aspects were missed. In addition, a micro-analysis was performed on a section from one transcript (see Appendix B), whereby each word was examined for possible meanings and metaphors. A section of one transcript was also laid out in different ways, for example as stanzas (Riessman, 1983) and segmented by character changes. These processes allowed the researcher to examine other ways of interpreting the data, and whether new/different narratives emerged. No new narratives arose which contradicted, or were not encompassed by, the existing interpretation.

**Credibility of the Analysis**

Qualitative research and its validity and credibility, has been the centre of many debates (Mays & Pope, 2000; Seale, 1999). Yardley (2008) suggests there are several strategies which can serve to increase the rigour of qualitative studies. Triangulation, which involves comparing different perspectives (e.g., a mother, father and child), was not possible within this study. Comparison of researchers' coding was not possible for all data, but the author's analysis of one transcript was seen and commented on by both supervisors. In addition, several aspects of the analysis were discussed within a peer support group. Participant feedback was not actively sought, but was enabled as all participants were provided with the researcher's contact details in case of questions or comments; none were received. Disconfirming data analysis, checking for instances where the data does not fit, or contradicts, the identified patterns, was done with all the data at several different stages. Finally, a full paper trail was retained, to ensure the full process could be traced if necessary (Koch, 1994).

## Findings

The findings below represent a shared plot which emerged from the 10 transcripts, and is organised into chapters. Chapters one and two explore the context of participants' stories, whilst chapter three represents the journey of therapy itself. Finally, chapter four describes the impact and influence of therapy on participants, both personally and professionally. Summary stories for each participant can be read in Appendix C-L.

### Chapter One: Being a Trainee – "The course was the stressor, the course was the problem" (Emma)

Within this chapter, participants frequently referred to the course as an influential character within their story. They personified "the course" as a singular entity with demands and expectations. The course played an important role in initiating participants' personal therapy journey, with six participants indicating it was the trigger for them seeking therapy: "[you are] being stretched and being a bit more vulnerable to, to your weaknesses, because you're being scrutinised and erm, assessed" (Lilly); "[I] very much went into therapy *because* I was training to be a clinical psychologist" (Emma). Research has indicated trainee clinical psychologists experience elevated levels of stress (Cushway, 1992). Incidents such as failing a placement or assignment were key events, described as catalysts for seeking therapy as "my world had just been destroyed" (Holly). Wosket (1999) describes how evaluation of trainee therapists' abilities may be experienced as evaluation of the whole self. Consequently, training can potentially have a substantial impact on trainees' wellbeing. Personal therapy can provide support during the stresses of the journey through training. Sophie described how:

> God, when I'm stressed, things do kind of escalate and then you're suddenly like shit, I need to get a grip on this again, and to know that there was somebody there that I could process that with week by week just felt quite containing.

Whilst participants' stories typically featured some aspect of training as motivation for seeking therapy, only Emma described any anger regarding this. She recalled making changes after failing a placement, because "they literally put a gun to my head." Kelley-Laine´ (2003) suggests metaphors allow verbal expression of psychic pain. Although Emma employed a jovial tone when relating this story, her metaphor suggests a lack of choice or control. Her word choice of "literally" also emphasises her experience of powerlessness.

In addition to providing support through the stressors of training, participants described how personal therapy was important in their journey of developing as a clinician. There were common themes within these stories, namely:

> We've all got things in our experience, in our history, that influence the way we are as people, but actually if we had them out in the open a bit more we might be able to give up some of the…bad habits that we have and the traps that we fall into (Lilly)

Many participants also thought it was important to experience the 'client role,' suggesting an ethical obligation to do so. However, Liz noted "you don't expect surgeons here to have gone through surgery, you know, to empathise with the experience of what it's like to go through surgery." The majority of qualitative studies with trainee therapists include responses valuing the opportunity to be a client (e.g., Moller et al.,; Rake & Paley, 2009). This is often connected to an ethical obligation to "practice what you preach" (Ivey & Waldeck, 2013, p. 3). However, Kumari (2011) suggests for individuals accessing personal therapy "without specific problems and at a time when they are emotionally stable" (p. 214) it is unlikely to increase empathy or awareness of a client's experience.

The cost of therapy featured within a number of participants' stories, with a shared narrative regarding the financial impact. Several participants used imagery to describe how the monetary cost came to represent their personal responsibility to maximise their use of

therapy: "Every minute was £1" (Emma), "I could almost hear the pounds ticking away" (Jen). Although some courses provided a budget for personal therapy, not all participants chose to utilise this. Helen personally funded her therapy, as "when you're on the course, everything is being monitored and evaluated and it kind of felt like that might be just another thing." Both Helen and Liz highlighted a lack of clarity in "what was the point of them giving us a budget for personal therapy." Trainees may feel there is an expectation from their course as to what competencies should develop from accessing personal therapy, considering all other activities are monitored and evaluated.

**Chapter Two: Stigma of Therapy – "Oh my god it's so shameful" (Sophie)**

Stigma was a significant character in the majority of participants' journeys, whose presence was felt because "we're clinical psychologists, we're the experts, we don't need therapy" (Annie). Jen reflected how dichotomous positions, or "othering," protected mental health professionals from considering they could be in their client's position. She posited, "I think it's this quite black and white assumption that gets made about strength and weaknesses, and cared for and caring." Richards (2010) discusses the dichotomy of "us and them" within mental health services, which implies individuals seeking mental health support are different, even abnormal. As Kitzinger and Wilkinson (1996) explain, "'we' use Other to define ourselves: 'we' understand ourselves in relation to what we are not" (p. 8). For clinicians, positioning themselves as separate to clients may reassert their own sanity and power (MacCallum, 2002). Consequently, any movement towards the "other" group could carry feelings of powerlessness, fear and shame. Only Lilly explicitly stated she did not feel any stigma during her journey, because "you're surrounded by psychologists all the time" who she felt understood.

A key event in Rachel's narrative was seeing another client leaving her therapist's house and wondering if they were an "*actual* patient" with "proper problems." Although she

used a jocular tone, this suggests a therapist's motivations for seeking therapy would differ to a non-therapist client's. However Norcross and Guy (2007) state "our presenting problems are, by and large, nearly identical to those of the educated populace seeking mental health services" (p.169). Similarly, Lavender (2003) describes how psychological difficulties exist on a continuum; consequently therapists are not "categorically different" from clients (p. 15).

Family and friends were also key characters within participants' stories, and could be unsupportive of their experiences as "you're mad, if you're going to therapy you've got problems" (Mary). Participants described fearing judgement from their therapist, particularly in terms of their competence as a clinical psychologist. Helen thought "she's gonna think you're a psychologist, you shouldn't have these issues." Liz considered lying to her therapist about her profession, and recalled feeling angry at an "unspoken set of judgements she would have about my suitability to be a therapist."

There was also a narrative shared by several participants regarding a sense of judgement from their training course, in response to their use of therapy. Helen felt it was "almost like a punishment" if the course suggested a trainee needed to access therapy. Emma also indicated feeling "beneath" her peers for accessing therapy. Mary noted her course "sold it" as professional development rather than therapy, which "makes you think there's something wrong with saying you're going for therapy."

These narratives suggest participants felt accessing therapy was indicative of a weakness which directly impacted on their suitability as a therapist. Many authors refer to the "wounded healer" (e.g. Barnett, 2007; Wheeler, 2002) which "suggests that healing power emerges from the healer's own woundedness" (Zerubavel & O'Dougherty-Wright, 2012, p. 482). Research indicates many who choose to train as a therapist have their own psychological wounds, which can enhance their effectiveness provided those wounds are

sufficiently understood (Cain, 2000; Gelso & Hayes, 2007). However authors also note concerns of the potential stigma, or judgment of their competence, if therapists disclosed the details of those wounds (Zerubavel & O'Dougherty-Wright, 2012, p. 482). This seems a difficult balance to manage, where one is encouraged to reflect and attend to personal "wounds," but it does not feel safe to do so.

**Chapter Three: The Therapy Process – "Scary but Exciting" (Holly)**

When describing their therapy journey, participants' beginning plot involved a number of motivations for seeking therapy. However, many waited until "crisis point:" "I had to have that point where I kind of started to fall apart a bit before I could go" (Helen). This may be due to the fears previously outlined, not wishing to be considered a lesser therapist. Events in participants' stories regarding their decision to seek therapy included "panic attacks," "an eating disorder," feeling "suicidal," and processing being adopted.

Several participants discussed the anxiety they experienced before their first session; "I was running late and I was feeling really stressed and then kind of knocking on her door with this rain pouring down" (Holly). Words such as "awkward," "scary," "exciting" and "claustrophobic" were used to describe the initial stages of therapy. With the exception of exciting, which referred to the potential of the process, these descriptors indicate fear or anxiety. These are feelings typically expressed by non-therapist clients of therapy (Howe, 1993), however these may be compounded for trainees if they anticipate judgement from their therapist.

All participants contributed to a shared narrative of the therapeutic relationship as key to enabling change and development on both a personal and professional level. Emma compared therapy to an "attachment process" which facilitates self-knowledge and affect regulation. Words such as "containment," "consistency" and "predictability" were used to describe positive therapeutic relationships. However the character of the therapist sometimes

changed within participants' stories, becoming seen as a person which led individuals to "hold back a little bit" (Holly) and become "conscious of affecting her" (Rachel).

Despite experiencing therapy positively overall, participants described a number of difficult emotions throughout their journey in response to being "open and vulnerable" (Mary). Participants felt "pissed off" (Liz) and "absolutely hated her" (Annie), perhaps in response to being "pushed outside their comfort zone" (Holly). These responses may be a reaction to their therapist's interpretations, or a defence against feelings aroused by the new attachment (Farber, Lippert & Nevas, 1995). Defence mechanisms are described as unconscious reactions to stress or anxiety, in order to protect the self (Lemma, 2003). If a therapist appears to confirm the trainee's "need" for therapy, this may be experienced as confirmation of their inner weakness or failings.

Liz's story included imagery such as hoping her negative feelings towards her therapist had been "invisible." She related this to fulfilling the character of a "good client," arriving on time and completing homework. This suggests she would have been a "bad client" had she displayed how she was truly feeling. If revealing emotional distress is felt to undermine an individual's suitability as a therapist, being open and honest is likely to be difficult. The sense of being "good" or "bad" also suggests a right and wrong, perhaps indicative of narratives within chapter one of an expectation for what "should" happen in therapy. It may also indicate expectations of her clients, and whether they are "good" or "bad."

Participants described a number of emotions they experienced during their therapy journey. Two participants utilised the same metaphor, but in contrasting ways. Liz expressed anger towards her therapist appearing "self-satisfied" when Liz cried, because "I've obviously hit the nail on the head." Conversely, Lilly's therapy lacked "those things that people say that absolutely dissolve you into tears because they hit the nail on the head."

This imagery suggests a precise action performed by the therapist to the client, causing a strong emotional reaction. Macran, Ross, Hardy and Shapiro (1999) relate this to the medical model of psychological disorder, whereby therapy is the treatment delivered by the therapist to the client. This could be described as an aggressive or delicate action, but irrespectively implies something deliberate, placing power with the therapist. However it may also reflect a physical sensation in response to the therapist's interpretations. Holly recalled one such occasion and experienced "the strongest physical reaction" which led her to feel "toxic."

A number of fears were described by participants, for example Lilly felt unable to say some of the "vile things" she wanted to for fear of being unwanted by her therapist. Jen described initial fears her therapist would expose her as a "wicked and horrible person," however her sense of safety developed as therapy progressed. Liz discussed the difficulties in knowing the "rules" of therapy and "what's the appropriate thing to do here." This may imply a fear of doing the wrong thing, and again wanting to be a "good client."

For several individuals, the therapy process was a "luxury and quite nice to have a space to just open up about everything about me" (Rachel). It was also appreciated not being "the one who sorted everyone else's problems out." This may relate to being "off duty" (Kottler, 2010, p. 48). However for some, their therapy journey included negative impacts. Liz's partner expressed concern she seemed "unhappy, really anxious, really down on yourself," whilst Sophie's sleep and mood deteriorated. She outlined the potential therapy trajectory:

> Start with like honeymoon period, it's fab, then this is a load of shit, it's making me feel like crap, you're not changing my life at all…and then if they can persevere with that…they won't go right up to honeymoon period again, they'll get to realistic.

The ending was a significant event within the therapy journey, and was experienced in different ways. Helen's was "gradual," whilst Liz's was "neat and a bit contrived." Participants agreed it was difficult to "know" the ending, but described signs such as "everything seemed to sort of just make sense, and fit" (Mary). The tone of these narratives was often wistful or sad, with Helen likening the ending to "bereavement." Liz highlighted a potential danger in accessing a short course of therapy, as "she'd kind of dug all this stuff up and now was just trying to pack it back down again in time to finish in 12 weeks."

For some, the relationship with their therapist was present within their journey beyond therapy. Both Annie and Rachel considered writing to their therapist, to "let her know that I'm alright" (Annie). Similarly, Helen wished she could tell her therapist about important life events. Farber et al., (1995) suggest "once an attachment relationship is established, it remains operative even in the physical absence of the attachment figure" (p. 208). Participants' responses indicate a continued importance of their therapist, which may be experienced as an "internal representation" (Arnold, Farber & Geller, 2004).

**Chapter Four: Impact of Therapy – "I became a much better therapist" (Jen)**

Throughout participants' stories, they described a number of personal and professional impacts of therapy. Holly and Lilly noticed positive changes in their relationships, with Holly taking "responsibility and ownership for feelings." In contrast, Sophie's journey led to a change in her sense of self, feeling "I don't fit very well" with her family. Several participants noted seeking more supportive friendships, and becoming more open with their feelings.

There were also changes in participants' relationships with themselves; they related feeling "happier with me" (Annie) and "ok with being good enough" (Holly). Conversely, Liz recalled becoming "self-obsessed" and wanting to "talk about ourselves endlessly." She, Annie and Mary commented on the experience of being listened to, when usually taking the

role of listener. Kottler (2010) notes how therapists often continue to listen to others' difficulties within their personal life. Personal therapy may provide a unique opportunity for trainees to focus on their own thoughts and feelings.

At the end, or later stages, of their therapy journey, all participants noted a substantial impact on their professional identity and clinical practice. This particularly arose from experiencing the client role and gaining "insight to how vulnerable you can feel, and how exposed" (Lilly). This allowed participants to reflect on different aspects of therapy, particularly how the therapeutic relationship did not rely on "using fancy words or models" (Helen). This also led participants to be more flexible, and attend to consistency within the therapy frame. Liz described discussing the rules of therapy with clients, to prevent them feeling like "the blundering person at the dinner party who doesn't know which knife and fork to use."

Whilst all participants noted positive impacts on their clinical work, some also noticed potentially negative effects. Jen's own story of experiencing therapy could lead her to become frustrated with clients, thinking "I've had to do all the hard work, you damn well should have to as well!" Both Mary and Jen reflected on the potential risk to "try and do what worked for you, for your client" (Mary). Although only two participants discussed this explicitly, the majority described changing their clinical practice in response to what was helpful/unhelpful in their own therapy. This implies an assumption clients would have similar preferences. Yalom (2002) recommends therapists should "create a new therapy for each patient" (p. 34), guided by each client's needs. Participants' responses suggest their own experience of therapy may affect their subsequent approach with clients.

A key event in both Lilly and Rachel's stories was seeing another client leaving their therapist's house and realising "I'm not just this special person that she sees just for me" (Rachel). This narrative seemed linked to feeling vulnerable:

> You ring the doorbell, and how long does it take them to answer the doorbell, and why aren't they answering, you know, who's in there and why, why are you keep-, I'm important, or who's more important than me? (Lilly)

Liz also described the "conveyor belt" of clients where "you're herded out and the next one comes in." These stories and imagery all relate to a sense of worth or value, as perceived by the therapist. This may relate to the transference experienced by participants, in response to the attachment formed with their therapist (Lemma, 2003). This led participants to reflect on the power of their own relationships with clients.

The different experiences during participants' journeys led to an increase in professional confidence; Emma thought "when I had therapy, my patient outcomes were so much better." Helen found therapy beneficial in building her emotional resilience, whilst Jen suggested "the more open we can be to ourselves, the more of ourselves there will be to bring into the room, and therefore the greater our capacity will be to imagine others' distress." Mary also stated "we owe it to the patients to have been able to at least know our own weaknesses or vulnerabilities and not put them on them."

## Discussion

All participants indicated personal therapy positively influenced them and their clinical work. These benefits of therapy echoed those within the published literature, including experiencing the client role, gaining empathy, and increasing self-awareness. Participants suggested their experiences allowed them to become better therapists, and that similar opportunities should be available to all trainee clinical psychologists. However, there were also narratives expressed which are not currently explored within the literature, which this discussion will now focus on exploring further.

Personal therapy can complement training as a therapist, and encourage personal and professional development (Norcross, 2005). However, a number of participants described

training itself as a significant factor in seeking therapy. Training as a clinical psychologist is typically stressful, as trainees are required to undertake emotive work, attend teaching, and perform academically (Schwartz-Mette, 2009). Some individuals may find aspects of delivering therapy personally distressing (Figley, 1995). Participants' suggestion that therapy was necessary in order to cope with these demands could imply course-provided support is inadequate for some trainees. Alternatively, trainees may feel unable to utilise the support available. Participants discussed the evaluative nature of training, therefore course-instigated sources of support may not be accessed for fear of negative appraisal.

Participants described a feeling of shame concerning accessing therapy as a trainee therapist, irrespective of their motivation for seeking it. Weiss (2004) discusses the attitude that "psychotherapists should be the prototypes of mental health," and the consequent fears of being considered "emotionally unstable or inadequate" (p. 96). Whilst participants described these as external judgements, these may also represent projected internal fears (Lemma, 2003). Authors have suggested therapists may feel threatened by needing help (Norcross & Geller, 2007) and feel an expectation to be "superhuman" (Farber, 2000, p. 343). This may be particularly so for trainee therapists, as they are regularly evaluated. Whilst working as a therapist requires emotional intelligence and resilience (Kottler, 2010), accessing therapy does not indicate a lack of these skills. Seeking support may in fact indicate strengths in self-awareness and resilience (Norcross & Geller, 2007; Wicks, 2008).

The shame described of accessing therapy is likely to affect individuals seeking support before reaching "crisis point." Participants described delaying therapy until it felt unavoidable, which is concerning. Individuals may experience further difficulties in coping with the demands of training, if support is not swiftly accessed. There is also a risk of negative impacts to client work (Farber, 2000). The BPS (2009) states psychologists should seek assistance if personal problems arise which may affect their work. However,

participants' responses suggest a narrative within the profession that it is unacceptable, even shameful, to experience feelings that clients present with.

The shame described by participants is indicative of a wider stigma regarding mental health difficulties (Corrigan, 2004). Although campaigns such as Time to Change (2008) aim to reduce this, Richards (2010) suggests their approach reinforces narratives that those accessing mental health services are "different." Whilst it seems logical to state this "us and them" dichotomy should be diminished, it may serve several purposes. Holding clients apart from oneself may allow therapists to contain clients' distress whilst remaining confident in their own wellbeing (Cain, 2000). There may also be a function for clients in portraying therapists as "superhuman," in order to trust them with their own difficulties. Some participants described holding back to protect their therapist. Youngson, Hames and Holley (2009) conducted a focus group, where several service-users commented on the importance of therapist strength, to "know they can cope with whatever the pain is" (p. 67). These factors should be kept in mind when considering how to reduce the perceived inequalities between "us" and "them."

**Limitations**

Several recruitment factors narrowed the sampling pool, such as some courses not retaining contact information for past trainees. Participants were self-selecting, therefore their experiences may differ from individuals who chose not to participate. Decisions regarding participation may have been affected by the researcher's profession, which could have created expectations of a particular agenda.

The findings of this study are not generalisable to all clinical psychology trainees, due to the small sample size. It is also not the aim of narrative research to provide findings that represent whole populations. There were also differences between participants which may have affected their experiences, such as their model/duration of therapy and whether they had

accessed therapy prior to training. However, participants expressed many similar narratives, suggesting a core of shared themes.

A significant limitation of the study is the gender bias; all participants were female. Whilst this is likely due to the higher proportion of females within the profession, narratives of male trainees accessing personal therapy may differ. Mahoney (1997) found that of 155 therapists, significantly more females than males had accessed personal therapy. This may be indicative of differing perspectives; Norcross and Guy (2007) suggest men, including male therapists, typically inhibit their emotions. Consequently, they may be less likely to seek therapy, and those who do may experience it differently to females. Further research exploring male therapists' experiences of personal therapy would be beneficial in developing this understanding.

**Implications and Future Research**

These findings have several implications for clinical psychology training courses. All participants emphasised the role of personal therapy in developing their clinical skills, therefore its inclusion in training could be further explored. It would also be valuable to further explore participants' claims their personal therapy made them a "better clinician," although this has proved difficult to measure in previous research.

As discussed, participants' responses suggest some difficulties within the current support available during training. Although courses are likely to offer numerous avenues of support, these may not be accessed for fear of negative evaluation. Training courses should consider the provision of external sources of support, such as personal therapy, or other confidential options. Future research could explore the sources of support available to, and utilised by, trainee clinical psychologists, which would in turn inform the development of training courses. It would also be informative for future research to include longitudinal studies with trainees throughout training, to capture any experiences of psychological

difficulties and their coping. This could help to decrease the sense that trainees should not encounter any emotional stresses of their own. It may also improve understanding of the most effective coping strategies for individuals during their clinical training.

There are a number of other explicit conversations which it would appear beneficial for clinical training courses to facilitate with trainees. Encouraging open discussions regarding the likelihood of experiencing psychological distress at times may reduce any sense of asking for help as a weakness. It would also be valuable to initiate conversations regarding the training course's position in relation to personal therapy. 'The course' was externalised as a singular entity, who could lead participants to feel powerless and shameful with regards to seeking therapy. Training courses should be mindful of this potential, and engage in open discussions concerning the possible consequences (both positive and negative) of personal therapy. They should also be transparent with their decisions regarding whether personal therapy is funded, and if it is what their expectations are for trainees accessing it. Participants could feel personal therapy was an "adjunct" rather than integrated into training, and consequently it continued to seem shameful. Course staff could also provide reflection and advice on aspects such as choosing models or therapists, the timing of therapy, and integrating the experience into their professional identity. Considering the role of the course within participants' narratives, and the implications outlined, it may be beneficial to address some of these with course staff nationally, for example at the Group of Trainers in Clinical Psychology conference.

There are also implications for the clinical psychology profession as a whole. The stigma surrounding personal therapy for clinical psychologists is concerning, but seemingly well established. Participants' narratives regarding the shame of attending therapy also suggest that those in the client role are somehow weaker, or lesser, than others. This may also reflect a societal attitude towards those accessing mental health services (Corrigan,

2004). The positives in seeking support for personal and professional distress or development should be emphasised and encouraged. As Youngson et al., (2009) state, we should be aiming for "a mutuality that, in reality, sees, believes and acts as if we are all on a continuum that means that at different times and stages in our lives sometimes we are the helper, and sometimes the helped" (p. 63). Further research exploring the potential stigma for trainee clinical psychologists in both accessing therapy and disclosing psychological distress would develop understanding of these conflicts.

## Conclusion

This study suggests personal therapy can provide valuable support to trainee clinical psychologists, including managing the stressors of clinical training. However, the therapy process can also lead to difficult emotions, and affect participants' sleep, mood and relationships. All but one participant described a sense of shame in accessing therapy as a trainee clinical psychologist, feeling they should be "more sorted." This has implications for the profession as a whole, and its approach to members' mental health and self-care.

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Table 1

*Demographic information regarding participants and their experiences of therapy*

| Demographics | No. n=10 |
|---|---|
| Gender | |
| Male | 0 |
| Female | 10 |
| Time since qualifying (years) | |
| Mean | 2.85 |
| SD (2.d.p.) | 2.97 |
| Range | 0.5-7 |
| Stage of training when began therapy | |
| Year 1 | 2 |
| Year 2 | 6 |
| Year 3 | 2 |
| Number of therapy sessions* | |
| Mean | 82 |
| SD (2.d.p.) | 87.44 |
| Range | 6-300 |
| Model of therapy | |
| Integrative | 3 |
| Cognitive Analytic Therapy | 1 |
| Psychodynamic/psychoanalytic | 6 |
| Funding source for therapy | |
| Self | 7 |
| Course | 1 |
| Both | 2 |

*Approximate number of therapy sessions during training; several participants continued personal therapy after qualifying

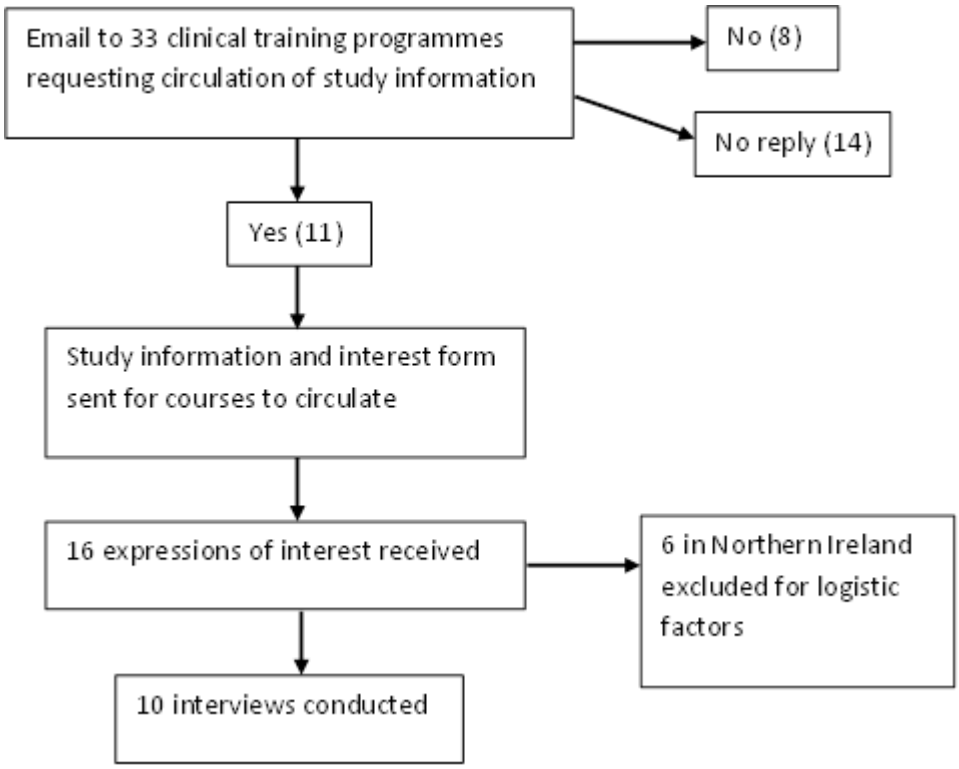


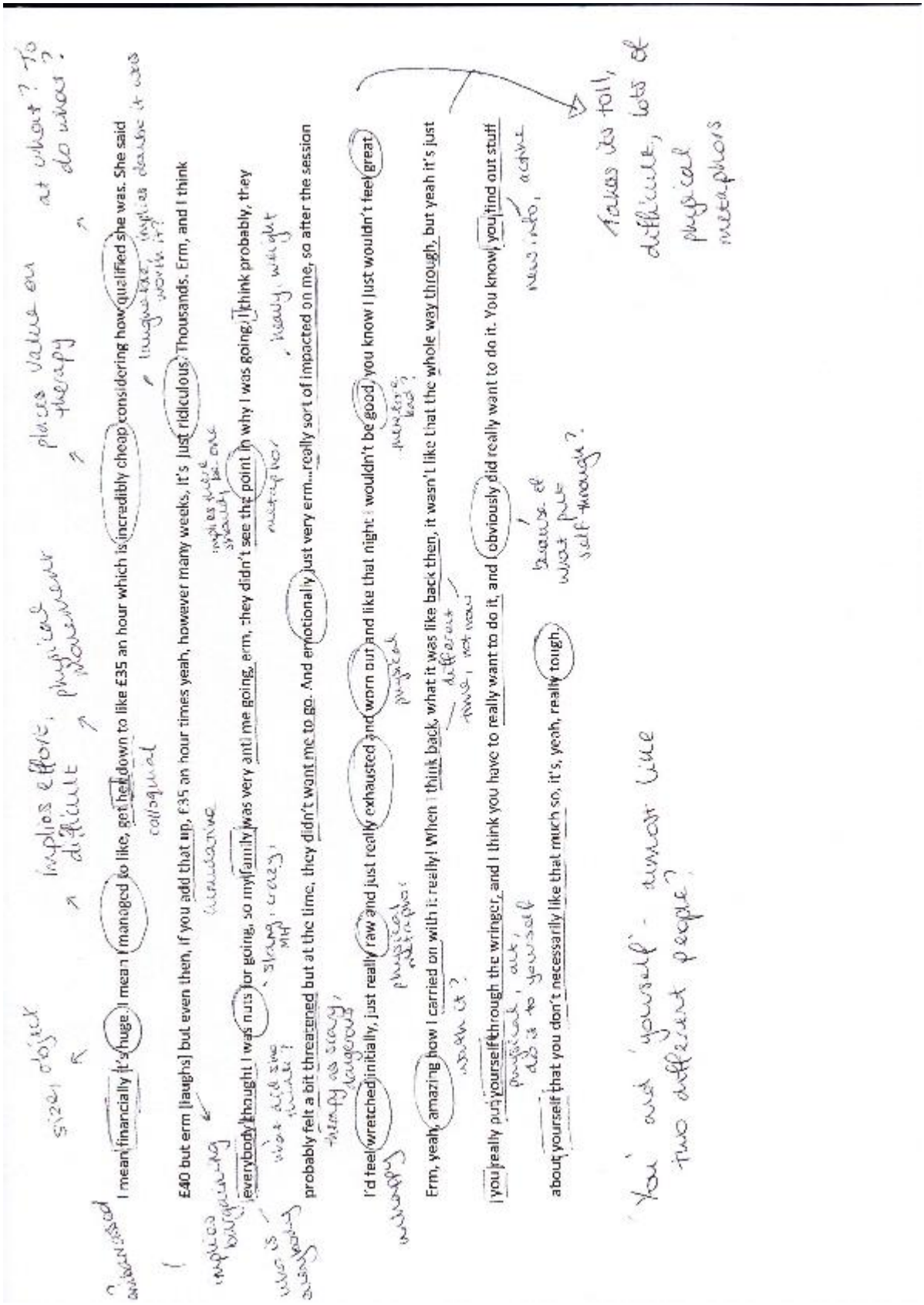

*Figure 1.* A Flowchart to Demonstrate the Recruitment Process

# Appendices

## Appendix A: An example of a table created for each transcript

| Plot | Narrative tone | Imagery | Characters | Changes in tone/pace | Themes |
|---|---|---|---|---|---|
| Emotional impact | Overall positive – some difficult experiences of positive impact | Having "extra space outside of supervision which is evaluative" "just to be yourself, just to have any emotion" and "not be judged"; worked alongside "peer support," combination led to "growing in confidence personally"; "not necessarily guided" on opening up, "hard for me especially as I can be quite a closed person"; difficult knowing "what to open up about" as think "that's not relevant"; try not to "pre-plan" but be "mindful of just going with the flow"; "luxury" to "have a space to just open up about everything about me"; "one person who probably knows lots about every side of me"; "lot closer to my family now than I think I was then" as things "that I did manage to sort of resolve"; "still hard to really fully be emotional" although "was tearful a lot…which I was always quite conscious of affecting her" "hard to really fully display yourself in every way"; "realise you do miss that" as "supposed to be open," "forces that" – becomes tearful; now "quite a different person" as before was "a really placid person" and "passive," now "saying everything and anything that's on my mind, even if I'm annoyed" – get comments from friends and colleagues; family "see me as quite different and quite assertive" but haven't discussed why; changes in "relationships" as "used therapy a lot to talk about guys," "she got a bit confused as to who was who" – "must be boring listening to all this boy talk"; some sessions which "would be emotional," meant to "keep a diary" as a way of "processing some of it and dealing with the emotions" but didn't last; driving home felt like "that's the boundary, that's the containment, in that room" – didn't think it "spilled over"; sometimes "used people to talk to again" if had "emotionally charged" session; "more up and down" between sessions, "conscious" of "what's on my mind"; when saw other clients, "found myself just sort of judging" "maybe she's an *actual* patient" with "proper problems" but "I'm not an actual patient" – "intrigued"; "a bit intrusive" and "devalued things" to see "it wasn't all about me"; notice little things like if "her husband's car was there," impact of changes – reflect on own client work if "chairs in the room move around" which may be "anxiety provoking" | Supervision<br>Self<br>Peers<br>Therapist<br>Family<br>Friends<br>Colleagues<br>Relationships<br>Therapist's clients<br>'Actual patients' | closed person, guarded – comes across in interview, careful with words; think that's not relevant – happening in interview, holding things back?; describing self as tearful, laughing; becomes tearful talking about missing therapist, laughing, ?embarrassed; boy talk – mocking self, laughing; actual patient – laughing at self, seems uncomfortable talking about how felt, pauses+ | Space to be yourself; growing in confidence; opening up; emotions in session; becoming assertive; impact on relationships; seeing other clients; impact on client work |

**Appendix B: Micro-analysis from one transcript**



## Appendix C: Annie's Summary Story

Annie sought therapy due to a number of factors, including personal circumstances, wanting to experience therapy herself, and be a "better therapist." Annie recalled being late for her first session, which was unlike her, and potentially reflected her initial ambivalence about therapy. Annie described not trusting her therapist initially and finding it "awkward" being asked personal questions. She reflected that therapy was a "huge commitment" but one she took for several years. Annie described finding herself very tired if she had sessions before work, and preferred them at the end of the day. She related this to her own clinical work, and being mindful of clients who have to go to work after sessions. Annie thought this could be particularly difficult when feeling "raw" after therapy, if left with difficult or unexpected feelings.

Annie purposely chose a psychodynamic model for her personal therapy, as she had been drawn to it through her own clinical work. Annie said that she had hoped the approach would allow her to resolve aspects of her childhood, and learn more about herself. She described having "a light-bulb moment" after sessions, when she realised things about herself which had been unconscious. Annie thought the fundamentals of the psychodynamic model, particularly the consistency in time, location and therapist, helped to build a sense of trust and containment with her therapist. She described paying attention to these factors in her own clinical work, in prioritising consistency, no matter what model she was working from.

Although Annie recalled having "no idea" where she would be at the end of therapy, she knew that she did not want to be where she was at the start. She remembered being shocked at how vulnerable she felt after some sessions. In terms of expectations, Annie wondered if she thought "I'll be sorted, all my problems will be gone" initially, but developed more realistic expectations over the course of therapy. She described this as being more comfortable with "not knowing."

Initially, Annie described feeling ambivalent towards her therapy, and that she "absolutely hated" her therapist. She thought this gave her an understanding of her own clients which she would otherwise not reach. Annie said she felt "incredibly criticised" and small, and angry at her therapist for "demanding to know all this stuff" without giving anything of herself. She said she persevered because she recognised a need to process aspects of her childhood, and because she had faith in the process. Finding out new things about herself helped to build trust between Annie and her therapist, as did her therapist's consistency in always being there.

Annie described the experience of being a client, which she thought had made her into a "good therapist." She related the difficulty in revealing "intimate problems" to a stranger, which has impacted on her own empathy and sensitivity with clients. Annie described not finding it easy to switch from being the "rescuing" person to the vulnerable one. She described feeling "wretched" after sessions, raw and exhausted. Annie explained that there were tough times where you "put yourself through the wringer," and it required really wanting to engage in therapy. Annie said it was difficult finding out things about herself she didn't like, but that the process of being accepted and validated within therapy was positive. Annie thought it was important for trainees to be able to be open about themselves, and that personal therapy should be part of training to be a therapist.

Annie's course was supportive of trainees accessing personal therapy, but it was not encouraged. She recalled aspects such as a reflective practice group and operating a reflecting team, which aimed to increase trainees' personal awareness. Annie described fearing that trainees who do not access therapy would put their own issues onto clients, and lack an awareness of how their baggage may impact on their work. She acknowledged that their awareness could develop through therapy or close friendships and family, but thought that all trainee therapists would benefit from personal therapy.

Annie described feeling there was a narrative that "we're clinical psychologists, we're the experts, we don't need therapy." Annie thought that many of her cohort would be "resistant" to therapy, and recalled others seeming threatened by a psychodynamic reflective practice group which they attended. She wondered if this was partly due to a pressure for trainees to appear competent in order to gain a place on clinical training, therefore not showing any weaknesses. Annie recalled feeling this way herself, and consequently not telling many people that she was accessing therapy. Annie recalled seeking support from her partner after sessions, as she would feel that she "couldn't really speak." She described not receiving much support from her family, who she thought felt threatened by her accessing therapy. Annie said that her sister pointed out how else she could have spent the money, not seeing the value in therapy.

Annie could not recall others around her explicitly noting differences from her therapy, but she described friendships and relationships changing. She said that is "much happier with myself," and through therapy came to terms with aspects of her childhood. Annie detailed sending her therapist a card which said "thank you for helping me to become the person I…wanted to become." These changes have led Annie to be more "assertive" and "honest" with others. Annie said the major thing to come from therapy was being able to recognise and be aware of her own feelings. This has also impacted on her clinical work, in being honest and transparent with clients. She also thought she was more likely to address "therapy interfering behaviours" and dynamics between herself and clients.

The process of paying for therapy was uncomfortable for Annie; she wondered if that was in feeling that she was paying somebody to listen to her problems, and whether they would choose to be there if they weren't being paid. Annie described the financial impact of accessing therapy which was "just ridiculous" over several years. Annie reflected that the NHS could feel like "stick a plaster on" when it's not possible to see clients long-term, but she also struggled with the idea of charging for therapy which was available through the NHS.

Annie said it had been difficult to know when to end therapy, as other difficult life events occurred which she wanted support through. She described thinking "you could go for the rest of your life" so it was necessary to draw a line under it at some point. Annie detailed several factors which led her to decide to end therapy, including moving further away and feeling that it had become less "professional" and "a bit too friendly." She related feeling concerned about her therapist's wellbeing as she knew more about her, which was unhelpful. Annie said that she does consider writing to her therapist to reassure her that she's ok. She reflected on not knowing how often her therapist thinks about her, but wanting her to know that she was ok.

## Appendix D: Emma's Summary Story

Emma described seeking therapy due to failing a placement during training. She felt it was helpful to have someone separate to the course to support her. Emma described the course itself as the catalyst, or "problem," which led her to access therapy. She felt it had been more needed, and consequently impacted more greatly, in her professional life rather than personal life.

The course had chosen Emma's model of therapy, and she found a local therapist through UKCP. She described being in a "period of crisis" and felt she did not have time to decide on a model herself. Emma wished the course had suggested she access therapy sooner, as it may have prevented her difficulties reaching the level they did. She described a number of issues she encountered with the course itself, and reflected that she would have been open to anything that would help. Emma said she felt "let down" and angry at the course, for not providing her with feedback sooner.

Emma described the various stressors of training, managing coursework and placements, as well as a personal life. Emma said she felt there was a demand to be flexible, such as moving for a placement, which she did not meet. She described needing stability and security in order to manage, but that the course "want you to give up your life." Emma said she became more flexible, which improved aspects of the course, but she felt they "put a gun to my head" to make this happen.

Due to feeling therapy had been mandated by her course, Emma remembered not wanting to be in therapy initially. She said she was open about going for therapy, but also felt it was sometimes "intrusive" having her peers know about her difficulties on the course. Emma described the different amounts she paid for sessions throughout therapy, depending on her salary. She recalled finding sessions less helpful when she paid more, as her awareness of its value increased; "every minute was £1." Emma reflected on the value of paying for therapy, and accessing longer term therapy than is available through the NHS.

Emma said that therapy allowed her to redefine herself, and become more reflective with others and herself. She felt personal therapy had greatly impacted on the way she related to people. This included thinking before acting, and greater transparency when she found things difficult. Emma related this to skills of mentalising and communication, which allowed her to think about others' needs and reactions. Emma also described forming a "needy relationship" with her therapist, which she said enabled her to be her "bold professional self" at work.

Emma also described a number of impacts of therapy on her professional development. She hypothesised that her patient outcomes were better as a result of her therapy. Emma said therapy allowed her to reflect more on her clinical work, and how it affected her. She also valued experiencing the role of client, including not being in a position of power. Emma noticed feeling more connected and sensitive with her patients after accessing therapy. As a result of these changes, Emma said she did not feel bitter towards the course, because their suggestion of personal therapy led to an improvement in her clinical work.

The relationship with her therapist was important to Emma, and how she valued the advice her therapist had given her. She also related times when their relationship felt more difficult, which was when Emma felt that her therapist had not thought about her. Emma

described a particular session where her therapist did not appear, and had forgotten about their appointment; Emma said she felt hurt, and that their relationship consequently broke down, although was now "healed." She also spoke about difficulties in their relationship after she qualified; Emma wondered if her therapist was mourning the loss of her as a trainee, which was echoed in her still paying a trainee rate. Emma thought that the role of therapy had been to develop a secure attachment with her therapist, which was something everyone needed to experience in some way. She described how individuals gain self-knowledge and affect regulation through attachment, which was valuable in the highly stressful context of training. Emma said it was "unrealistic" to expect trainees to be exposed to human distress daily, and not find it stressful or need additional support. Emma thought personal therapy should be mandatory for clinical psychology trainees, although wondered how that might be resourced.

Therapy was now "tapering off" for Emma but she was not sure if or when she would fully discontinue. She described it as a "prop," which continues to aid her both personally and professionally. Emma said that on finishing the course, she felt the "demon" was gone and that therapy would end; however life events since then have meant that therapy continued to be helpful. Emma spoke positively about the flexibility of her therapy, and knowing she could discontinue and return at any time.

Emma described how hypocritical she felt the profession of clinical psychology could be, as they are seemingly ashamed of having personal problems, despite providing treatment for others with similar difficulties. She also spoke of the risk of identifying with patients, and not processing it fully, which she thought was vital as a therapist. Emma described the stigma she felt was attached to accessing personal therapy within the profession. She said she felt beneath her peers, and like a failure, when she attended therapy during training. Emma described "layers of shame" associated with this, and feeling that attending therapy meant there was something shameful about the "whole of you." Emma thought this stigma was societal, as it is often not talked about, despite many others having accessed therapy themselves.

## Appendix E: Helen's Summary Story

Helen discussed her motivation for seeking therapy, which included wanting to "sort my own issues out" and understand her own background and experiences. She wondered if the demands of the course had contributed to increasing her awareness of some of her own difficulties. Helen explained her course funded 6 sessions of personal therapy for trainees, but she felt that it was unrealistic that she would achieve much within 6 sessions, and wanted something "just for me" without the connection to the course. Helen worried that 6 sessions would not feel contained, and that confidentiality may be compromised if her therapist had connections to the course.

Helen described wanting to seek therapy for some time, but needing to start to "fall apart" before she could overcome her sense that she should be able to cope without therapy. She felt personal therapy fitted well with her second year of training, and enabled her to reach a healthy position emotionally by the time she qualified. Helen wondered if therapy would have been more difficult in first year, as she was still settling in, but thought that all trainees would benefit from accessing it at some point.

In order to find her therapist, Helen used routes such as google, and the British Association of Psychotherapists website. She chose her therapist based on the warmth of her tone on her website, and the appearance of her consultation room which seemed homely. Helen noted that the physical environment of her therapy sessions had played a key role in her experience. She felt that it was a nurturing environment, which felt safe and friendly. Helen reflected on her own clinical experience, where she often saw clients in buildings with paint peeling, which feels old and forgotten about. Helen described putting plants and cushions into her room to create a more welcoming feel for clients.

Helen described a number of fears she held before entering therapy. This included: whether she would be able to cope with the demands of the course; the process of opening up to somebody else and potentially being judged by them; will the therapist be able to help; could this negatively affect my relationships or the problem; how will I know what to talk about. Helen also spoke of feeling guilty, knowing that she would be speaking about difficulties with family members. Helen wondered if her fears would have been greater if her therapist had also been a clinical psychologist, in terms of feeling inadequate as a clinician and comparing her practice to theirs.

The therapeutic relationship played a key role in allaying Helen's fears about therapy, particularly being judged as not "good enough." Helen said that her therapist was highly validating, warm and non-judgemental. This enabled Helen to develop trust in her therapist, and a sense of feeling cared for. She described the importance of feeling contained by her therapist, who provided a calm, safe place for her. Helen related these experiences to her own practice, thinking about "what makes a good psychologist." She also noted how during one session where her therapist appeared tired, she began to wonder about the therapist's life and what may have changed – however this only occurred once.

Helen said personal therapy had been equal to clinical training in terms of its value in her professional development. She recognised she could see aspects of herself in various clients, which would potentially be "dangerous" if she had not processed her own experiences. Helen described the overlap between personal and professional drivers for the profession of clinical psychology. She wondered if for many, there can be a desire to rescue

others, and without adequate development of their emotional resilience and reflection, there is a danger of burning out. Helen felt that personal therapy enabled her to be more reflective, to remain objective and maintain resilience despite difficult dynamics with clients. She also felt that therapy allowed her to recognise and strengthen her own identity, and feel positively towards herself.

Helen described the experience of being a client, which she disliked initially, particularly as she felt exposed and vulnerable. She reflected on feeling a need to be a "good enough" patient, including being reflective and psychological, especially considering her profession. Helen's experiences of being a client also affected her own clinical work, including being able to have less control within sessions, and react to what emerges.

Helen reflected on the experience of being both a client and a trainee concurrently, which was challenging at times. She remembered being expected to achieve certain competencies or tasks in training, such as formulation diagrams, which her therapist did not undertake. She also noted the difference in pace between expectations in the NHS, and in her own therapy. Helen found this affected her own practice, in recognising that focusing on specific tasks sometimes led to her neglecting her warmth and curiosity. It also led to her recognising that her learning on the course could be used flexibly, and thinking about her own style and approach. Helen mentioned feeling that therapy supported her during the stressors of the course, and she wondered if she would have been able to complete training without it.

Although Helen described having no specific expectations for therapy, she felt that it had exceeded any she might have had. She felt that she would not be in such a good place if she had not accessed therapy, both personally and professionally. Helen described a number of impacts on her relationships from accessing personal therapy. This included ending some friendships which were unhelpful, and creating more boundaries with family members. She also described a healthier relationship with herself, where she allowed herself to enjoy thing and be spoiled without feeling guilty.

Helen shared that she was accessing personal therapy with a number of friends, but never her family. She described recommending therapy to others, and felt they supported her seeking it. Helen found the course less supportive, reacting to her disclosure of struggling with a suggestion of being more resilient. She thought they generally promoted a sense that trainees should not be experiencing difficulties, despite the highly stressful nature of training. Helen reflected that this attitude is also held my much of society, that psychologists "should have sorted themselves out." She described how therapy allowed her to see that her experiences were a natural response to life pressures, and emphasised the need for greater support from courses.

Helen discussed how difficult "knowing" the ending of therapy was. She remembered discussing several times whether to end therapy, but feeling that she was not yet ready. Helen thought that the end came when she felt able to recognise and adapt her negative thought patterns, and contain herself emotionally. She described a gradual ending, where the time between sessions progressively extended. This helped to reduce the pain of ending, although Helen still likened it to a bereavement and missed her therapist afterwards.

## Appendix F: Holly's Summary Story

Holly described the training course as one of the stressors which led her to seek therapy. She recognised that most trainees are "high achievers" with a strong academic history, including herself. Holly said that when she failed a piece of work on the course, it felt as though "my world had just been destroyed." This led to her feeling "insecure" in her own abilities. Holly explained that her interest in clinical psychology had partly arisen from growing up in several different countries, and consequently witnessing the differences in those cultures. She expected that clinical psychology would be hard work, but also exciting, which she also expected from therapy.

Holly explained that her course offered to fund some sessions of personal therapy. She was interested in accessing CAT therapy, because the model fitted "my way of thinking." However, Holly said that she was disappointed with her own diagrammatic formulation as it "narrowed things down" and she "got lost in it." She wondered if her expectations had been too high, as she had expected to find the diagram valuable.

Arranging her initial assessment had been anxiety provoking, Holly remembered, and it was "awkward" negotiating the fee and other logistics. She described the initial appointment, and feeling "really stressed" at the outset. Holly thought it was valuable to have experienced this anxiety, in order to understand how her own clients may feel. She said that therapy was a space to reflect on her own values and beliefs, which allowed her to become less hard on herself. She described becoming "ok with being good enough" and recognising that life was not as "black and white" as she had thought. Although Holly still felt she had high standards, she described placing a limit on how much work she would do.

Holly said she and her therapist initially agreed a set number of sessions, which they later extended. Holly liked her therapist's creativity in drawing on different models, and sources such as art, literature and drama from her home country. This allowed her to reflect on how therapy can relate to "so many different parts of a person." Holly said she now considers this within her own clinical work, and how clients' own cultural nuances may affect them. Holly remembered being "really challenging" with her therapist at times, but felt that her therapist didn't judge her for it. She said feeling her therapist still liked her, despite the challenges, helped to build the trust in their relationship. Holly reflected that if she struggles to connect with a client, she ensures she discusses it within supervision, because "I don't think that you can work with somebody if you don't like them."

There was an incident which led Holly to feel "furious" at her therapist, and consequently was "angry and challenging" within sessions. She valued that her therapist remained with her, and explored her anger together. Holly reflected that she learnt when people let you down, it does not have to end the relationship. She described encouraging clients to express their anger within therapy, and similarly staying with them throughout it. Holly explained that anger within therapy can come from pushing clients outside their comfort zone, challenging their own roles within relationship difficulties. She explained that in her own clinical work, she now recognises clients may become angry or frustrated, and that it's a reasonable reaction to the difficult aspects of therapy.

Holly recalled being surprised by her own reaction to one session, where her therapist had asked her a difficult question. She described feeling "toxic" for the week following, and shocked at the strength of her physical reaction to a psychological impact.

Holly said that within her clinical work, she now feels ok to sit with a client's defence mechanisms, be it humour, kindness or intellectualism, despite any awkwardness. Holly also said that her therapist was warm, empathic and not afraid to challenge her. She reflected on the importance of a good therapeutic relationship, and the impact that can have.

Holly detailed the importance of the therapeutic environment, and said that in her own clinical work she now tries to use side rooms rather than talking to clients on inpatient wards. Holly said her therapy had demonstrated the importance of boundaries, and that it was possible to feel heard and contained whilst keeping to session times. Holly reflected on her own client work, and realising clients may "test" their therapists and it was important not to become "defensive".

Therapy exceeded Holly's expectations, and she thought it greatly increased her self-awareness. She reported a greater understanding of why she was who she was, and choosing not to make some changes because she liked things the way they were. Holly described personal therapy as impacting on her general relationships, in taking them to "another level." She particularly related this to her relationship with her husband, and with herself. Others also noted changes in Holly as a result of therapy, such as being more relaxed and less ruled by "shoulds and shouldn'ts." She also described taking "responsibility for how I was feeling," which she also discussed in her own clinical work now. Holly gave the example of moving from saying "you make me feel angry" to "I feel angry."

Holly recalled wanting to extend their number of agreed therapy sessions, but feeling it would be "needy" to do so. Her therapist told her that if she wanted more, she could ask for them, and they would explore her reasons for wanting further therapy. Holly wondered if her sense of being needy in asking for further therapy partly arose from her own personality, and experiences in clinical psychology. She reflected that the profession involved paying attention to other people's wants, which often led to becoming "quite poor at listening to yourself" and your own needs. Holly said she decided to finish therapy at the same time as finishing training. She described feeling "strong enough in myself" to continue the work herself, and that they had addressed "one layer" but a break would allow further layers to become visible. Holly said she did return to therapy a while later, when she was going through a "tough time."

There was no ideal time to go through therapy, Holly thought, as it could be helpful both during a crisis and not. She said that training had "held up a mirror to me," and required trainees to confront hard things about themselves. Holly thought it was a good opportunity to work through that with a therapist, but acknowledged that she had been open and ready for change. She recommended that any trainee therapist access personal therapy, because it is only by knowing oneself that one can "help people at a deeper level." Holly thought that clinicians who had not experienced personal therapy were more likely to have blind spots, and be at "risk of acting things out on clients." She described a group of psychologists which she aligned herself with, who thought personal therapy was "hugely important" and a valuable learning experience. Holly thought it was helpful that some courses provided short term personal therapy, but wondered if it could "only take you so far." Holly thought experiencing the client role enabled a greater empathy, regardless of the model. She described feeling that she would be a different person and clinician without having had that experience.

## Appendix G: Jen's Summary Story

Jen described being "avoidant" in the first year of training, having not reflected on her own personal history prior to the course. She said she began to struggle as aspects of clients' disclosures resonated with her, but she saw herself as "an island" who did not need help. Jen explained her tutor advised her to seek personal therapy, which "sounded like a nightmare." She did not follow his advice until several months later when her struggles intensified. Jen described reaching "crisis point," in terms of both her health and her academic progress. She said she felt her career was at risk, which motivated her to follow her tutor's advice and seek therapy. Jen reflected she "hated going" to therapy for the first year, but continued as she believed that therapy would enable her to continue training. Whilst undertaking therapy Jen also took some time off from training in order to attend to her own emotional wellbeing.

Therapy initially did not feel "safe" for Jen, and she recalled interpreting everything as confirmation that she was a "terrible person." She reflected she would interpret her therapist's attempts to offer positive or containing comments as critical in some way. Jen said she left therapy several times as it felt "overwhelming." However, as the safety of the relationship increased, Jen said she found therapy less "aversive." There were a number of things which added to her sense of safety: the consistency of the model; developing a routine; taking a risk and being ok; getting through bad episodes together. This eventually led to a sense that "being Jen was ok."

Jen described the function of personal therapy for her, in recognising her own assumptions and interpretations. She remembered the psychological theories she had learned "clicked" as she experienced therapy for herself. Jen emphasised the need to, as clinicians, increase one's capacity to be open and imagine others' distress, which she gained through her own therapy. There was a substantial impact of personal therapy on Jen's professional development; she suggested it was "transforming" and that her clinical practice was significantly different. She noted that clients seemed more able to make important disclosures to her after she returned to the course, and felt she was a "better therapist." Jen explained that therapy enabled her to understand her trigger points, and likely reactions to different situations. She also described utilising supervision differently, moving from business-like supervision to a more open and reflective space. Jen reflected that she has subsequently developed an openness and safe, containing space for her own supervisees. Jen wondered if there was a risk at times of over-identifying with clients, and assuming that what worked in her own therapy would work for them; however she thought that generally she was able to respond more helpfully to clients. Jen explained that accessing personal therapy whilst training could be difficult at times, but her course were supportive and flexible. Jen said her reflective ability went from being highlighted as a major learning need to her greatest strength.

Jen described both positive and negative aspects of being both a client and trainee concurrently. She said it reduced any barriers between "us and them" and she was now more likely to challenge any "othering" in her teams. Jen also felt it had increased her compassion, as she had experienced both psychological distress and the process of therapy. Conversely, Jen recalled sometimes feeling frustrated with clients if they are not taking responsibility, thinking "I've done it, so can you!" Overall though, Jen said therapy had been "enhancing of my clinical skills." Jen described how many people around her had

commented on changes in her since accessing therapy; she felt that she had gone from wearing “a coat of armour” to being “the person that I was always meant to be.” Jen said she was now an advocate for personal therapy, and encouraged her colleagues to consider it. Jen reflected on the global impact of therapy on her life, and thought that without it, she probably would not now be a psychologist. She described the changes in her emotional wellbeing, her relationships, and moving from an “empty” to “fulfilled and meaningful” life. Regarding whether personal therapy should be mandatory for clinical psychologists, Jen was undecided. She wondered how one could be a therapist without experiencing it for oneself, but thought that making it obligatory would alter its dynamic and expectations.

Jen described the process of paying for therapy, which she felt added to her sense of personal responsibility for it. She reflected that although she believed therapy should be freely accessible through the NHS, she wondered if this could create a sense of complacency amongst service users. Jen remembered feeling an extra pressure for therapy to be useful, because she was paying for it. She described it as “gutting” knowing that many cannot afford to access the length of therapy that she experienced, and felt “privileged” to have been in a position to do so.

Although Jen said that her course was very supportive of her personal therapy, she wondered if there was still some stigma surrounding clinical psychologists accessing therapy. She suggested this may depend on the reason for seeking therapy, where those experiencing mental health difficulties experienced greater stigma than those seeking to augment their training. Jen described perceiving some stigma from her coursemates regarding her own use of personal therapy. She wondered if some people had concerns regarding the impact of her struggles on her work, but felt this was the responsibility of herself and her supervisors to manage. Jen described feeling supported by her course throughout her difficulties and use of therapy. She said they “triumphed with me” when she qualified. Jen said she did not feel any stigma from her course for accessing therapy, but that she did from a few other members of her cohort. Jen also described the process of “othering,” which she related to mental health difficulties. She wondered if creating dichotomous positions allowed professionals to protect themselves from imagining they could experience a mental health difficulty. Jen also reflected that there may be a sense that “as helping professionals we should be the strong ones,” which added to the stigma of seeking personal therapy.

Regarding her expectations for therapy, Jen thought they were predominantly negative. She had expected to have her inner badness confirmed, and to mostly sit in silence as she “had nothing to say.” Jen reflected that her negative expectations were not met, and that therapy surpassed any positive expectations she could have had. Jen said that although she had hoped to overcome her difficulties, this seemed “unsurmountable.” Jen explained she was still accessing personal therapy, but less frequently than previously. She related several instances where she had considered ending therapy, but through discussions with her therapist decided to continue as it was still useful. Jen described sometimes feeling conflicted as she no longer experienced the difficulties for which she initially accessed therapy, but still found it added to her personal and professional development.

## Appendix H: Lilly's Summary Story

Lilly described the events which led to her seeking therapy in her second year of training. She said her supervisor, who had become Lilly's "secure base" during the first year of training, became pregnant and went on maternity leave. Lilly explained that her second supervisor was also away, and she felt uncontained and anxious. She also spoke about a psychodynamic exercise at university, during which she made some connections between her current feelings and her history, regarding her adoption. Lilly said that this was "the beginning of the falling apart of me," after which she began to argue with her family. Lilly was reluctant to seek therapy, but felt "desperate" and so made an appointment. Her therapist was humanistic, and Lilly said she found it helpful to have 6-8 sessions to talk and get validation. Lilly reflected on the process of paying for therapy, which was mostly in order to access therapy immediately. She also spoke about knowing that she could afford to pay, and not wanting to take an "NHS slot" of someone who could not afford to pay for it.

Lilly described it as a positive experience to be "on the other side of the fence" in order to gain insight into the vulnerability of being in therapy. She said that she found it difficult to be open about her emotions, and found it helpful to write them down instead. Although it was a "destabilising" experience prior to therapy, Lilly said she now felt more stable and balanced. Lilly reflected on the importance of acknowledging one's own experiences, and its potential impact on clinical work. She said therapy gave her a "unique" experience, and she thought she would return several times during her life. Lilly thought the biggest impact on her professional development was experiencing the client role, including forming a therapeutic relationship in a short time. She became "acutely aware" of various aspects, such as waiting for the therapist to answer her door, and seeing other clients at her therapist's house. She recalled noticing how powerful those factors could be, and linking it to her lectures at university. Lilly said that she felt "emotionally exhausted" after her sessions, which has led her to reflect on her own practice and be "mindful of packaging people up" at the end of a session. Lilly said she did not feel any stigma about having accessed therapy, and did not hide it from others. She thought that her awareness of what clients may feel had increased, and she described being careful not to "probe too deeply" with her own clients if she was not able to offer ongoing support.

Sharing emotions with her therapist was sometimes difficult for Lilly, which she related to wanting to be "perfect" in order to be wanted. She reflected that she was very controlled within therapy, but recalled once going home and writing down some of her thoughts and feelings. Lilly read these to her therapist at her next session and cried, which she felt was a "turning point." She wondered if accessing therapy with a psychodynamic frame may have accessed her emotions more easily, but appreciated having somebody "who just listened and was very validating." Lilly thought that she had projected her own need to feel special onto her therapist, which may also have been processed differently in another model. Lilly said she would have liked a therapist who challenged her more, which she would seek if she returned to therapy. She explained she has considered returning to therapy, but it would likely be "when it all comes crashing down again." Lilly described fearing it would be another destabilising experience, and using the financial implications to "justify" delaying it. She recognised not wanting to wait until crisis point, but feeling it wasn't an urgent priority at the moment.

Lilly described herself as “bad at endings,” which she also applied to ending therapy. She wondered if it had felt “too painful” to keep going, whilst also planning her wedding which she wanted to be happy. Lilly thought her therapist had been agreeable to ending, but perhaps wasn’t given much choice. She agreed to return to her therapist after getting married, but didn’t. Lilly related this to avoiding the ending, and wondered how her therapist felt that she hadn’t returned. Lilly explained at the end of her therapy, she felt “a sense of achievement” at acknowledging aspects of her past, which felt “enough” at the time. She thought it would feel self-indulgent having similar conversations with friends, whereas it felt ok in therapy she was paying for. Lilly said she felt “more balanced” at the end of therapy, but that it was a “first step.” She described having to “drag” things in her unconscious up herself, whereas she had hoped that her therapist would provide that for her.

Lilly said that therapy both tested and changed some of her relationships, and was very powerful. She explained that her mum would let her be upset briefly then want “to fix it,” whereas therapy allowed Lilly to cry and “be heard,” and acknowledge the situation. Lilly said therapy “cement[ed]” her relationship with her husband, as she had “underestimated his capacity to understand me” and support her. She also described friends supporting her, and acknowledging some of the difficulties she had experienced.

There are aspects of training which often necessitated seeking extra support, Lilly thought; this included being “scrutinised,” having resources “stretched” and being required to reflect on the interaction between the personal and the professional. Lilly thought the ongoing reflection and scrutiny could lead trainees to be vulnerable. She recalled events on placement echoing some of her own vulnerabilities, which made feeling contained by her supervisor important. Lilly described her supervisor as consistent, predictable and containing, and reflected that she would have liked a more psychoanalytic model of therapy to echo these aspects. Lilly thought lots of her peers accessed therapy during their training, as it was a “safe” place to do so. She did not think there was any judgement or stigma for accessing therapy, and found there were many supportive options on the course.

Lilly described how her reflections on therapy “continue to evolve,” as her life develops. She recalled having few expectations for therapy, but acknowledging that perhaps there were some negative feelings regarding her adoption to process. Lilly wondered if she had initially expected to “do it well and do it once,” whereas she now expected to return to therapy later in her life. Lilly said that each part of her training journey, including personal therapy, shaped her. She advocated personal therapy for everyone, in order to recognise potential traps. Lilly thought that clinical training was a good time to access personal therapy, as it is “the tie in your career when you’re the most malleable” and being shaped. The time available during training to reflect on one’s experiences and their personal and professional development was important, Lilly thought. She emphasised the importance of reflecting on each experience and thinking how has it changed or influenced you, and how will you change your practice. Lilly explained that although other aspects of her training journey also contributed to her development, there was something “unique” about therapy.

## Appendix I: Liz's Summary Story

Liz's main motivation for accessing personal therapy was to experience the "other side" and learn from someone "in the field." Liz's course funded the majority of her sessions, with her paying for the final two. She chose to access CAT because she was interested in the model. Liz recalled her therapist emphasising the purpose of therapy wouldn't be for Liz to learn techniques, which Liz inwardly disagreed with.

Liz said she "hated therapy," which she found difficult as it was a process she recommended for clients. Although it was helpful, she often felt "pissed off" and resentful of her therapist. Liz recalled feeling she was "going through the motions" and continuing with therapy because the course funded it, rather than because it was useful. She acknowledged she learnt a lot about herself, but didn't enjoy the process. Liz hoped her therapist was unaware of her "rage and apathy," although said it caused her to wonder what her own clients may be feeling but not sharing with her.

Liz remembered being reluctant to do homework, and generally did it shortly before a session. She hoped her therapist considered her a "good patient," as she would arrive with it completed. Liz felt annoyed with her therapist for things such as fiddling with her hands, and finishing sessions early. Liz explained her therapist sometimes misinterpreted what she said, or placed greater significance on things than she felt was appropriate; putting "2 and 2 together there and kind of made a 5." Liz was "assertive" in sharing what she disagreed with, but felt her therapist maintained her formulation. She felt annoyed that she was vulnerable and trusting her therapist, who then did not hear her and misunderstood.

Liz described herself "railing against the vulnerability" and becoming angry, because therapy could feel exposing. She related feeling it was "embarrassing to be struggling with anything" as a psychologist, and that it was a "painful process" which her therapist was not always gentle with. Liz said it was difficult to experience the role reversal, and was surprised by her emotional reactions. She recalled that when she was emotionally raw, her therapist reacted with a "self-satisfied look" that crying was proof of therapy working.

Considering herself "emotionally literate," Liz wondered if this was undermined by feeling emotionally vulnerable in therapy. She thought there was a socialisation within the profession that "therapy and psychological distress was for other people out there" and not "the helpers." Liz related this to embarrassment she experienced during therapy, worrying her therapist would judge her as unsuitable to be a psychologist. She recalled considering not revealing her profession to her therapist, but did not want to build a relationship from a lie. Liz wondered if some of her anger came from feeling that her therapist would be judging her competency, and consequently noting that her therapist "wasn't perfect" either.

Liz recalled processing therapy sessions whilst travelling home. She said her therapist never asked how she felt after previous sessions, and consequently she didn't feel able to share her reflections. Liz related feeling unsure of the therapy "rules" and what was ok to say. She felt uncertain of what was appropriate, although now thought that it was "absurd" given the intimate content of their discussions. Liz experienced a "power differential" within therapy. She reflected on the role of paying for therapy, and recalled thinking "I'm bloody paying for this" which didn't fit with the "power imbalance" she experienced.

Liz described wanting to be a "good client," arriving on time, completing her homework and engaging with therapy. Liz recalled wanting to please her therapist and gain

approval, despite not particularly liking her. She related this to not wanting her therapist to judge her as unsuitable for clinical psychology. Liz said therapy caused her to become "self-obsessed," as she began to "analyse it endlessly." She wondered if this was partly due to being people who generally listened to others, enjoying the role reversal that "you can pay people and they have to listen." Liz also felt she had gone to therapy without difficulties, but through the therapy process had become "emotionally raw and quite wobbly." She recalled thinking therapy was "making me worse," a view which her partner shared as he saw her becoming unhappy and anxious. Liz linked this to her own clinical practice, in wondering whether some clients opt out of therapy as "digging all of this stuff out" is unhelpful.

The experience of being a client was "disorienting" for Liz. She said it felt the therapeutic goal was for her to cry, rather than "thinking and talking." Liz remembered one incident where she cried, but due to embarrassment at the shock of her therapist's question. Liz remembered finding it frustrating when she recognised "tricks" her therapist used as aspects of her own clinical practice. She said it felt "alienating" at times to be a client, and described the pressure to "produce the goods" and "fill that hour." Liz described the therapy ending as "contrived," and that she was "obliged" to say it had been helpful. She recalled feeling that because they had a set number of sessions, it was necessary to "round it off neatly." Liz said she felt annoyed her therapist had "dug all this stuff up and now was just trying to pack it back down again in time to finish."

There were a number of influences of personal therapy on Liz's own clinical work. This included questioning clients to ascertain their feelings towards therapy, and acknowledging some days therapy is not helpful. Liz explained that having reflected on her own ambivalence, she may have clients who arrive on time, with their homework completed, but spends time exploring how they feel about it. She also said she pays more attention to a client's life outside of the session, and to process aspects such as seeing other clients in the waiting room. Liz described how she explicitly discusses the "rules" of therapy so clients don't feel they're "breaching etiquette." This included acknowledging how "weird" and "contrived" therapy conversations can seem. She also checks in with how clients felt after the previous session, as she would have liked that in her own therapy.

Liz thought the "point" of personal therapy had been unclear, in terms of the course's expectations. She said everyone felt it was intuitively a good idea, but were unable to articulate why. Liz described it as an "adjunct" to training, separate to the course. It was labelled personal development, which Liz felt suggested "none of you will actually have kind of real, therapeutic issues." She wondered how the number of sessions was determined, as it would be difficult to address much within the short space of time. Liz thought there was a lack of linking personal therapy to the course, as it was never visited in terms of whether trainees found it useful. She thought this added to a sense of therapy being "shameful" and not something to discuss. Liz wondered if there was a narrative that it was "unethical" to expect clients to undertake if you haven't; however she compared this to a surgeon, and not expecting them to experience surgery in order to "empathise with the experience."

Liz thought there were a number of assumptions made within the profession, and narratives on the course appeared "us and them," separated into trainees who are "all of sound mental health" and those who they help. She didn't think there was encouragement of blurring those boundaries, and the stress of the course was portrayed as an opportunity to show how "brilliantly psychological" one's anxiety management was. In contrast, Liz now considered we're all "humans" with "stress and anxiety just like everyone else."

## Appendix J: Mary's Summary Story

Mary explained her course offered five sessions of therapeutic consultation, but portrayed it as not personal therapy. She experienced it all as personal therapy, but felt the course's stance suggested there would be something wrong with that. Mary discussed her motivations for seeking therapy, which she initially described as wanting to experience a model she was interested in, and making use of the sessions offered by her course. However, she described how her therapist recognised that there may be other reasons, but she was "trying to protect" herself. Mary explained that there were no major life events which led to her seeking therapy, but more a sense that she could get more from her life through understanding herself better.

Choosing her therapist was predominantly based on location and model, Mary said. However, her therapist voiced a curiosity regarding her choice of a male therapist, considering her own difficult relationship with her father. Mary recalled liking that her therapist asked these challenging questions, but knew a friend who found it intrusive when her therapist touched on her defences. Mary described seeking a psychodynamic psychotherapist because she was drawn to the model, in particular its way of relating to clients and seeking meaning from them; this also connected to the way Mary liked to work with clients herself.

Mary explained that she had always planned to have 7 sessions of therapy, but wondered if it ended a bit abruptly. She described being in a "honeymoon," where things had improved, and also struggling to justify paying for further sessions. Mary also said she did not want to continue personal therapy whilst juggling demands of the course. Although Mary's experience of therapy was a positive one, there were a number of difficulties she experienced during the process. She described feeling emotionally numb after sessions, and wanting time alone. It was useful to experience this in terms of being in a client's shoes, but she also described finding it difficult to manage this in addition to demands of the training. Mary said that she often cried in sessions, and struggled at times to be open and vulnerable. She related one experience where she felt angry at her therapist when she felt he had given her bad advice, but did not feel able to tell him how she felt.

Mary spoke positively of the experience of having someone to be there for her, and reflected that although she was often there for other people, it was more difficult to seek support for herself. She suggested it was difficult to trust others with such personal information or concerns, whereas therapy was somewhere safe to go to. Mary described feeling scared of her vulnerability within therapy, as she discussed things she had not previously talked about with anybody. She said she did not feel unable to cope with the emotions, but it was a difficult experience.

Sharing personal difficulties was something that Mary reflected she was not always comfortable doing. She thought that although she was open and warm with her friends, she may not reveal her inner feelings. She wondered if, in being there for others, she had become used to holding things in. Mary also related this to not disclosing any personal difficulties to supervisors, which she thought was partly due to a message when she was an assistant that supervision was not the same as therapy. However, she described becoming snappy and stressed if she was not able to share her feelings when working with complex clients.

Mary said that she had told her family and some of her friends that she was accessing personal therapy, but reflected that there were friends with whom she had a lighter relationship with and therefore did not disclose it to them. She reflected on the difficulty of relating the therapy process to others, as she felt unable to put much of the experience into words. Mary described a number of impacts on her relationships from accessing personal therapy. Her time in therapy enabled her to recognise unhelpful patterns in her relationships. Consequently, she was able to make changes, and met a new partner who she is now married to. Mary also reflected that she became more aware of the types of people she valued, both romantically and in friendships.

Mary explained how she felt some people around her would benefit from accessing personal therapy, to help with stress and other difficulties. She related that her mum had accessed some counselling days through work, which had enabled her to be more calm and containing day to day. Mary wondered if some people tried to access therapeutic effects without saying they attended therapy, for example through a woman's group. Mary wondered if therapy is more effective when the client, herself included, is receptive to thinking psychologically and is ready to challenge themselves and reflect on different aspects of their experience.

The process of being a trainee and client concurrently was something which Mary described as difficult at times. She recalled times where she would note something useful her therapist did, and attempt to incorporate it into her own clinical practice. Mary reflected on the difficulty of balancing training, where she felt monitored and required to follow specific therapy structures, with therapy, which seemed to be more of a "conversation." Mary said that other members of her cohort seemed to consider personal therapy as self-indulgent, which she found "bizarre." Mary wondered how therapists could understand and contain their own reactions, or countertransference, if they were unaware of their own triggers. She considered personal therapy "vital" for knowing our own weaknesses and vulnerabilities, so as to prevent adding them to work with complex clients and their families.

Mary spoke positively of experiencing personal therapy whilst training. She wondered if first year would be too soon, and found that second year worked well. Mary said that there may be individuals who found it impacted on them too much, and consequently there needed to be an autonomy regarding its timing and length. Mary wondered if some trainees with little experience of the psychodynamic model would find personal therapy with a psychotherapist frustrating, due to the lack of clear answers or direction. However she found it a very beneficial model, and was amazed at how much changed in just seven sessions. Mary thought this change was partly due to her own openness and motivation to working in that way, and being challenged. She recognised that she had felt able to make positive changes, although she wondered what else could have happened had she continued therapy. Mary explained that she has considered returning to therapy, and would still like to do so, although she had not yet arranged it. She wondered if this was due to feeling scared of what may come from it.

## Appendix K: Rachel's Summary Story

Rachel explained her decision to seek personal therapy came from conversations with other psychologists who had accessed therapy. She added that through supervision and reflection, she'd become interested in the psychodynamic model and thought it would be useful to experience the client role. Rachel said she wanted to explore her background, but also recognised a pattern in her relationships which she wanted to address. She found her therapist through a website, and sought an "explorative and lengthier therapy" within the psychodynamic model.

The cost of therapy could have acted as a barrier, Rachel thought, but she justified it as professional development. She related feeling resentful on occasion for having to pay for a session that she couldn't go to, either because of holiday or extenuating circumstances. Rachel reflected on the process of negotiating a price, and handing over a cheque, which felt more formal and contradicted the "personal aspects" of therapy. She said that paying for therapy made her value it, and added to her commitment.

Rachel described the value of having space "to be yourself" in therapy, without feeling judged. She thought therapy worked in combination with supervision and peer support, to allow her to grow in confidence both personally and professionally. Rachel spoke about experiencing the client role, and experiencing the anxieties regarding attending sessions. She reflected on the difference in boundaries between NHS and private practices, as she attended her therapist's house for their sessions. Rachel recalled seeing another client leaving the house, and was shocked by her emotional reaction that she was not "just for me." She described not knowing what to open up about, and dismissing things as "not important." Rachel said she moved from thinking beforehand about what to discuss at the next session to being more "mindful of going with the flow." Rachel described herself as quite closed, and found it to be a "luxury" to have someone to open up to. She said it was hard to be "fully emotional," but was often tearful. Rachel became tearful whilst speaking about it, as she said she missed having that safe space and opportunity to be open.

Rachel described a number of emotional impacts of therapy, which could be difficult to manage. She recalled feeling emotional after sessions, and initially keeping a reflective diary. Rachel said she felt contained by the sessions, but would sometimes feel drained afterwards, or talked to friends if she felt upset. Rachel recalled seeing other clients at her therapist's house and wondering if they were an "*actual* patient" with "proper problems," but found that knowing her therapist had other clients felt "intrusive" and "devalued" her own therapy. She related this to her own practice and how clients may find small changes, such as chairs moving, unsettling. Rachel noted that since accessing therapy, she had become more assertive and speaking her mind. She said that previously she was a placid, passive person, and that others have commented on the change in her.

Rachel also described a number of impacts from therapy on her professional development. This included increased confidence in her clinical work, considering analysis of dreams within both her own and clients' therapy, and being in touch with her own feelings more. Rachel wondered if through training, she was striving to do things "properly" and follow a specific model, whereas therapy encouraged her to "just be me." She reflected she would like to apply this to meetings, but did not feel so able to. Rachel described herself as more emotionally "in-tune" since accessing therapy. She related her experience of the psychodynamic model, including aspects such as time boundaries and silences. Although she

would have liked more flexibility at times, she wondered how helpful that would have been as the formality helped to contain her within the session. Rachel recalled feeling resentful at times of not being able to schedule social things at her regular therapy time, but recognised the importance of routine. She also noted that within her own clinical work, it could feel chaotic without a regular time to meet.

Rachel spoke about the experience of accessing therapy whilst also being a trainee. She thought it fitted well, in terms of developing as both a person and a therapist. Rachel wondered if it would have been useful to start therapy at the beginning of training, or even before, in order to help process the transitions. She said there were times when therapy felt like a burden on her pressured time, but that overall she felt it should be advocated and encouraged more for trainees. Although her course were supportive of trainees undertaking therapy, Rachel wondered if it could have been more integrated. She said it felt fragmented at times, feeling "this is me as a trainee, this is me as a client, this is me in placement" rather than all being part of becoming a clinical psychologist.

The ending of therapy arose from several factors, including Rachel's therapist retiring and extra demands of the course. She recalled her therapist saying some clients chose to write to her after therapy ended, which Rachel had not done but still considered doing at times. She recalled her therapist asking her how she would spend the time after therapy ended, and encouraging her to continue using it to "nurture" herself. Rachel described moving from personal content to more professional content within therapy, and finding she was beginning to repeat herself, which seemed to be signals that it was approaching the end. She also said that she felt more confident in her relationships, and that the financial implications were also a factor. Rachel said that she has considered returning to therapy, but that "life gets in the way." Rachel wondered how different therapy with another clinician would be. She said that she had needed someone nurturing, but if she returned to therapy now would like someone who would challenge her more.

Attending therapy was something Rachel said she was open about and didn't hide from others, but found that other psychologists were easier to talk to about it. Rachel described talking to her sisters and friends, but found that non-psychologists could be unsure of why she was accessing therapy. She thought that openly discussing her experiences also encouraged some friends to think that it may be useful for themselves. Rachel thought approximately 5-10 of the 35 members of her cohort had accessed therapy. She discussed the moral aspects of seeking therapy, and wondered if there was an unethical element to working with clients without having resolved any personal issues. Rachel also described the importance of experiencing the client role, to increase empathy and understanding. She said accessing therapy encouraged her to consider that it was not only for those with mental health problems, but for "anyone's growth." Rachel wondered if it would be useful to have experiences of other models of therapy, to increase her understanding of those.

Rachel discussed the differences between private and NHS therapy, which she felt her therapy had allowed her to reflect on. She thought that aspects such as consistency, commitment and placing value on therapy would be helpful to apply within the NHS. However, she also spoke about the challenges of private work, where a wage is not guaranteed and factors such as location are not a personal decision. Rachel wondered how working privately may affect the dynamics of therapy, in having to operate as a business and define boundaries such as taking calls.

## Appendix L: Sophie's Summary Story

Sophie described "no specific event" which led her to seek therapy; she felt she used her placement requirement as her agenda, whilst underneath she felt there was work to do with regards to her relationships and intimacy.

Sophie's initial therapist did not feel like a "good match," and so she discontinued after 2 months. Sophie described a coldness and inflexibility to the therapist, where Sophie felt no control within the relationship. She found many of their conversations unhelpful, resulting in a "battle" of silence. Several months after ending therapy, Sophie decided to find another therapist, who was warm and a "good match." Sophie said she felt sad when she considered her own clients, who had no choice of therapist. Sophie's therapist's disclosure was greater than she expected, which she found validating and reduced her own sense of shame. Sophie wondered if this was partly due to their shared profession, which led her therapist to disclose more.

The therapy process was far from linear; Sophie described times where things seemed to get worse as she started to look at things more. She remembered having a break in therapy, and wondered what it was like in the NHS where that may not be possible. Sophie felt that therapy could be a support in dealing with stressors on the course, but it required balance as it could also add stress when exploring emotional factors whilst working in a demanding job. These reflections influenced Sophie's perception of her clients' journeys, which were also likely to have fluctuations.

With regards to the therapy timeline, Sophie described feeling there had been a battle at the start, in order for her to be completely open with her therapist. The character of the ideal trainee/clinician featured several times in Sophie's story. She described many fears regarding her therapist's judgement of her adequacy or worthiness as a trainee, if she were honest and open. She also related feeling that as a clinical psychologist, she should be "sorted" and without any difficulties. However, Sophie felt her therapist was non-judgemental, which enabled Sophie to feel more comfortable. Sophie felt her experiences of her "impossible time" affected her own work with clients; she felt more able to consider why a client may make her feel inadequate, or if they are threatened at the prospect of being helped.

Sophie felt concerned that she would be in therapy forever, but did not feel like the end of training equated to the end of therapy. She described difficulties in engaging in therapy to begin with, and accessing difficult feelings. Sophie wondered when she would feel comfortable ending therapy, and acknowledged some embarrassment at spending several years in therapy. She felt that personal therapy had enabled her to reach a point where when new obstacles or insecurities arose, she could understand them and know that they will pass. Sophie felt she now felt more comfortable opening up to people, but was aware that the relationship with her therapist would have to end eventually. Sophie described a difficult balance between wanting or needing therapy; she wanted to ensure she was using it, and found the idea of depending on it quite threatening. Sophie found personal therapy an "eye opener" in recognising she felt threatened by needs and wants.

Accessing personal therapy influenced Sophie's professional development in a number of ways. She felt that therapy had increased her understanding and empathy for clients, moving from seeing the profession as "patients and staff" to "we're all individuals,

we've all been through a life." Sophie felt this understanding was only possible through the experience of being a client herself. She also felt that therapy had affected her confidence as a clinician, in both a positive and negative way. On one hand, it allowed her to appreciate the complexity of life, and consequently limited by the superficial nature of what she could offer to complex clients within the NHS. Conversely, she wondered if this enabled her to better understand why some clients may not be making progress in a short term therapy.

Sophie felt that receiving therapy from a particular model affected what she believes in for her own clients, for example exploring interpersonal aspects and transference. She reflected on the difficulties when teams wanted specific models or techniques, when she valued the process of listening and reflecting, showing to clients that "you really have heard, held and then processed for them something, and then you're giving it back." For Sophie, a key aspect of her personal therapy had been having the time to fully explore why "I've turned out the way I am." She now felt happy with herself, but recognised it had not been an easy process. Sophie reflected on the difficulties within the NHS of only offering short term therapy, which may be effective in achieving "here and now" goals, but less so in gaining a deeper understanding of what's "made you as you are."

There were times when Sophie felt the boundary between therapy and supervision appeared to blur, as she would bring things to therapy regarding clients she found challenging or upsetting. She reflected that if she worked in any job, she would no doubt bring aspects to therapy, but as they are from similar professions it feels sometimes inappropriate. Sophie found it helpful to be able to consider certain aspects of client work in therapy, as it helped her to understand herself better. This had led her to consider seeking supervision within the same model as her therapy, as she found it such a helpful approach.

Sophie felt her experiences of personal therapy had impacted on a number of her relationships. She recognised that many of her friends were now those who had also experienced therapy, or were generally more reflective, which she also related to their interests in more flexible approaches to therapy. Sophie described the "struggle" of relating to her family, as she no longer feels that she "fits" very well. She wondered if this was due to therapy causing her to see things differently, and she" mourned" the lack of understanding from those she sought it from. However, Sophie recognised that she was able to seek out others who she could relate to and feel accepted by.

Sophie felt there were a number of differing opinions towards personal therapy, which resulted in her finding it difficult to hold onto her own. She thought many clinicians made the assumption that their colleagues would not have accessed therapy; however, when she "admitted" it to others, often they also had personal experiences of it. Sophie felt there was some stigma in having accessed personal therapy from some people, although not from her training course.

Overall, Sophie reflected that therapy did not feel great, or solve everything, but had made her more solid as a person for the rest of her life. She acknowledged that although there were difficult aspects of therapy, it was necessary in order to get the gains from it. She felt that therapy had enabled her to understand what makes her vulnerable to withdrawing, and engaging in unhealthy coping patterns, as well as building her strength to cope with the stressful demands of her job.

## Appendix K: Author Guidelines for British Journal of Clinical Psychology

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

(a) reports of empirical studies likely to further our understanding of psychology

(b) critical reviews of the literature

(c) theoretical contributions Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

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# Section Three: Critical Appraisal

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# Critical Appraisal

This research study explored clinical psychologists' experiences of accessing personal therapy during training. The findings support previous research suggesting personal therapy provides a unique experience which promotes both personal and professional development (Norcross 2005). All participants considered their therapy to have impacted positively upon their abilities as a clinician. It also affected their relationship with themselves and with others. However, the findings also suggested the stressors of clinical psychology training themselves could be the catalyst for individuals seeking therapy.

A previously unexplored narrative with this population was the stigma perceived by participants regarding their use of personal therapy. Individuals reported feeling ashamed of accessing therapy, as it suggested a weakness or failure in their suitability as a therapist. This attitude that clinical psychologists should be "sorted" (Helen; Sophie) was perceived from peers, friends and family, and training courses themselves. There was also a fear that participants' therapists would judge the individual's clinical competence in the context of their therapy content.

This critical appraisal reflects on key aspects of the empirical research process, including decisions and challenges faced. This represents an opportunity to explore some of my "story" with regards to the research; consequently these reflections are organised into five chapters: Choosing to research personal therapy; narrative interviews; the difference between research and therapy; using narrative analysis; and the personal impact of the research.

## Chapter One: Choosing to Research Personal Therapy

My interest in personal therapy arose from several experiences, beginning with my own therapy when I was young, in response to a stressful transition. I also recognised from an early age my own tendency to support others through difficult emotions or events. These roles are not uncommon for those who choose to train as therapists (Kottler, 2010; Norcross

& Guy, 2007). Whilst I enjoyed these responsibilities, I later noted the danger in being a 'rescuer,' tendencies often exhibited by those in caring professions (Gabbard, 2010). Although these actions could fulfil a personal need, they often left me feeling drained and neglecting other needs. As I pursued my career in clinical psychology I became more aware of the importance of exploring my own relational patterns, in order to separate them from a client's. Potter (2014) describes the "helper's dance list," a number of help giving/receiving patterns which therapists may engage in. I found this particularly helpful in recognising some of the "dances" which I may be drawn into with clients.

During my induction to clinical training, the concept of personal therapy was highlighted. I felt it would be a positive opportunity to experience receiving therapy whilst training to deliver it, and to become more familiar with my own vulnerabilities. My training course offered six sessions of "mini-CAT," which I began in June 2012. I found the process valuable in recognising some of my reciprocal roles and how they may affect my clinical work. However I also found it difficult sometimes to be open with my thoughts and feelings, knowing there were a limited number of sessions. These, and other, experiences furthered my interest in therapy for therapists. I also noted a lack of research regarding personal therapy for clinical psychology trainees. Although some research with other trainee therapists is likely to be applicable to trainee clinical psychologists, I noted the majority has been conducted with individuals accessing mandatory therapy. The mandatory aspect has been described with frustration and anger (e.g., Rizq & Target, 2010) and therefore may affect individuals' experiences of therapy.

When developing the protocol for the research study, I considered whether to specify what "personal therapy" was, in terms of inclusion/exclusion criteria. It seemed a difficult concept to define, as something could be experienced as therapeutic regardless of length or model. I decided to stipulate only that participants considered it to have been personal

therapy. I also did not want to exclude those who could not financially afford to access long-term therapy. I considered whether to interview current trainees, or qualified clinicians. I decided to interview clinical psychologists who had accessed personal therapy whilst training in order to allow reflection of its role within their training journey, and the subsequent impact of the experience (de Vaus, 2006).

**Chapter Two: Narrative Interviews**

I was aware of the potential for my role to influence the research throughout the process (Murray, 2003). As a trainee clinical psychologist, I was in the role that participants would be reflecting on; consequently I could be considered an "insider-outsider" interviewer (Dwyer & Buckle, 2009). I wondered if potential participants would expect me to be seeking a particular narrative regarding personal therapy. Although I worded the information sheet from a neutral standpoint, participants are likely to "make hypotheses about what the interviewer wants to hear and what they probably already know" (Jovchelovitch & Bauer, 2000, p. 65). As professionals delivering therapy, they may have felt obliged to deliver positive stories regarding their experiences. Alternatively, they may have thought the research's purpose was to develop personal therapy, and therefore feel obligated to explore its limitations or drawbacks.

During the interviewing stage of the research process, I wrote in my reflective diary: "Noticed they referred to me as a trainee within their narratives, conscious of my role?" Instances included "training was enough to deal with…you know that" (Lilly), "maybe you've got a different experience" (Liz). Annie also seemed conscious of offending or upsetting me; "not saying you think this," "not all trainees are like that," "sorry if I'm saying the wrong thing," "type of people attracted to clinical psychology – I don't mean you."

This sense of my position may have had numerous impacts upon the research process. Participants may have felt more able to share difficult aspects of their journey, such as

feelings of shame or stress, if they felt I was able to empathise and understand. Dwyer and Buckle (2009) suggest being an "insider" researcher can allow "more rapid and more complete acceptance" (p. 58) which facilitates greater openness. However, the dual role can also lead participants to not fully describe their experiences, due to an assumed knowledge. It can also lead the researcher to suppose they understand a participant's narrative, without seeking clarification or further exploration (LaSala, 2003). The narratives above also indicate a potential for participants to apologise for their thoughts or experiences, which may indicate a lack of comfort in sharing them.

Within the interviews, the majority of responses were positive regarding personal therapy as an opportunity. However, there were also a number of difficulties described by participants, such as feeling angry towards the therapist and struggling with some emotions. One participant said she "hated therapy," and reflected on what that meant considering the career she was investing in. It is difficult to know what enabled participants to share both their helpful and unhelpful experiences of personal therapy. They may have considered it important to share different aspects of their journey, to reflect fully on the experience. I also felt I had built a rapport with each participant, which may have contributed to their comfort in sharing their stories.

Stuhlmiller (2001) has suggested, "to get the story, the researcher must conduct himself or herself in a way conducive to fostering disclosure from the narrator" (p. 67). A qualitative interview is essentially a "social interaction" (Pezalla, Pettigrew & Miller-Day, 2012, p. 166), which is influenced by both the interviewer and interviewee. By adopting an empathic and supportive interviewing style, this likely increased participants' comfort in sharing emotive stories (Murray, 2003). Sophie commented "you're smiling which is helpful" after describing her difficulties with her first therapist who was "a blank slate." I also noticed myself nodding, or displaying sympathetic expressions. Mallozzi (2009)

describes these as “empathic moves” (p. 1055) which maintain the relational energy of the interview.

Having completed the interviews, I feel that approaching the project from a narrative analysis standpoint also contributed to participants’ comfort in sharing these experiences. Murray (2003) notes how narrative interviews give participants more “central control in shaping the agenda” (p. 101). The opening question of the interview implies no assumptions or expectations, and allows participants to share any aspect of their story (Riessman, 2008). It also allows for exploration of these stories without a particular hypothesis to be answered.

Participants’ responses to the narrative style of interview, particularly starting with a non-directive, open question, were unexpected. I noted in my reflective diary:
“She seemed to flounder quite quickly, asking for guidance from me after a few minutes.” This was the case for most participants, asking for prompts quite soon into the interview. Murray (2003) notes the open nature of narrative interviews can cause anxiety and even suspicion. I wondered if participants also had expectations of a research interview, which typically are more structured. One participant described the difficulty in knowing the “rules of therapy,” and I wondered if there were also implicit rules of a research interview, which perhaps they thought I was “breaking.” In response to this, I began to briefly introduce the participant to the style of interview before it commenced. However, the lack of structure also became seen as a “rule,” with Rachel saying “you can guide me now, I don’t know if you’re allowed to?” I found it challenging to remain silent at times, feeling a pull to provide prompts. However, I later wrote: “Really interesting to see how silences lead to new stories. I wonder if we’d have accessed them otherwise.” Howitt (2010) suggests silences ensure the participant’s narrative is not interrupted, and encourages them to answer thoughtfully. Participants seemed to become more comfortable with the style of interview throughout, and were able to relate a number of stories with minimal prompting.

**Chapter Three: Difference Between Research and Therapy**

One aspect which I explored within my reflective journal on a regular basis was the overlaps between research interviews and therapy. It is not unusual for researchers who are also therapists to feel "pulled between their role[s]" (Gilbert, 2001, p. 13). Both qualitative research and psychotherapy can seek to make meaning from another's responses (Hart & Crawford-Wright, 1999). Many of the active listening skills encouraged for therapists are also relevant and useful when conducting a research interview (Howitt, 2010). Bordeau (2000) suggests further overlaps; that both research and therapy seek to empower others, and share a structure where one individual discloses large amounts of personal information.

Participation within research interviews has been suggested to have some therapeutic benefits (Birch & Miller, 2000; Dickson-Swift, James, Kippen & Liamputtong, 2008). Several of the participants commented afterwards that they had enjoyed the process, which allowed them to reflect on therapy in a new way. I considered one of my roles within the interview to be to enable participants to share and explore different aspects of their experiences, including those which felt upsetting or difficult. This also echoes the purpose of therapy, in allowing clients to share their stories and reflect on their experiences (Dickson-Swift et al., 2008). A key difference, for me, was in the responses offered to participants. In therapy, I would perhaps offer interpretations, or develop a formulation with the client. In research interviews, my responses or reactions were typically to encourage further narration or seek clarification. The motivations can also differ between research and therapy, as Hart and Crawford-Wright (1999) argue; in therapy, the therapist aims to help the client, whereas in research the participant aims to help the researcher.

At times, I found my dual-role difficult to navigate. This was particularly so when participants made significant disclosures such as childhood abuse, an eating disorder, feelings about being adopted, marital decisions regarding whether to have children, and previous

suicidal ideation. Facilitating participants' disclosures is a large role of the interviewer (Dickson-Swift, James, Kippen & Liamputtong, 2007), although some authors describe the risk of interviewees revealing more than intended in response to a rapport with the researcher (Kvale, 1996). I felt pleased participants were able to share these experiences with me, and that I was able to hear these difficult parts of their stories. These disclosures were often later in the interview, which may suggest their sense of comfort and safety had built. There were also instances where participants became tearful within the interviews. However, I also felt unsure how to react; my natural response was one of empathy, but I was uncertain to what extent I should display this. Seidman (2006) cautions against allowing the rapport to interfere with the neutrality of the interview, whereas others suggest expressing empathy allows a less threatening environment to develop (Malozzi, 2009).

I explored this within my reflective journal, and also in conversation with peers. I realised I had focussed on there *having* to be a difference between therapy and research. I reflected that there was an overlap, and having experience as a clinician may be a strength as a researcher. I believe some of the skills I have learnt as a therapist also allowed participants to make significant self-disclosures, and feel both heard and understood within the interview. Dickson-Swift et al., (2007) emphasise the need for researchers to exhibit caring and empathic behaviours towards participants, particularly if they experience distress. This also positions the participant as a human, whereas a neutral researcher can treat participants as a "research object" (Rapley, 2004, p. 19). This may, of course, have guided the interview in some ways. Some authors suggest anything other than a neutral stance will bias the story (Weiss, 1994). However, Rapley (2004) argues neutrality within a research interview is a myth, considering the interaction required between interviewer and interviewee.

Considering the narratives expressed by participants regarding the perceived shame surrounding personal therapy, I wonder how they would have experienced a lack of emotion

from me. Participants may have felt this was further negative judgement of their psychological distress and use of therapy. This may in turn have affected their subsequent narratives, and potentially caused some emotional distress for them. Owens (2006) suggests the "success or failure of any given narrative is a collaborative venture between the teller and the listener" (p. 1161). I aimed to remain as neutral as possible towards the topic, whilst displaying interest and warmth (Fielding & Thomas, 2001). I do not consider this the "right" way to conduct all interviews, but an approach that fitted my own values and the research aims.

**Chapter Four: Using Narrative Analysis**

The research question was: How is personal therapy experienced and understood by clinical psychologists who accessed it during their training. After reading several texts regarding qualitative research I decided, with agreement from my supervisors, that narrative analysis would be the most appropriate method to use. The philosophy underpinning narrative analysis was one I felt drawn to. That is, that human experience is understood and expressed in storied form (Squire, 2008). My previous experience of qualitative analysis had employed different methods, which seemed to break participants' responses into small chunks without context (Riessman, 2008). I valued the potential to explore participants' responses more deeply, including any imagery and metaphors used. There was also a paucity of narrative research regarding clinical psychologists' experiences of personal therapy.

Narrative analysis is recommended when conducting research with marginalised populations, whose voice has previously been suppressed or unheard (Hendry, 2007). I did not initially think this would apply to clinical psychologists. However, whilst conducting the analysis, I realised this assumption may have been unfounded. Participants' stories regarding the stigma of accessing personal therapy were not particularly explored within the current literature. They related to thoughts and feelings participants felt they "shouldn't have."

There were also potentially "controversial" narratives expressed, such as disliking being in therapy despite working as a therapist. These link to societal discourses, and give voice to narratives which may not feel encouraged or supported. It is suggested that the open nature of narrative interviews creates "possibilities that are not visible when attention is restricted to question-answer exchanges" (Riessman, 2008, p. 23). I wonder if these stories would have been expressed using a different approach.

Conducting the interviews themselves also led to a number of challenges and reflections, in addition to those already outlined. For example, some texts suggest interviewers should make notes during narrative interviews, to aid with deeper exploration of stories (Wengraf, 2001). However this can mean the interviewer's attention is divided between listening and writing (Howitt, 2010). It can also distract the participant, wondering what is being written, or why. This echoed my own previous experience of taking notes within qualitative interviews. Consequently, I decided not to take notes during these interviews. This had both costs and benefits; I had to hold more information in mind, but I felt more present within the interviews. I may not have fully explored all the participants' stories without written prompts, but I felt more able to "hear" the ones they did share.

Having transcribed the interviews I began to conduct the analysis. I found it initially anxiety provoking that there is no definitive guide to narrative analysis (Smith & Sparkes, 2006). Kiesinger (1998) suggests researchers often feel "terrified and overwhelmed" (p. 84) when beginning analysis, considering the vast amount of data collected. I also wanted to know I was doing it "right." I felt paralysed by a responsibility to be a "good enough" researcher and do justice to the stories participants had trusted me with. I read several texts, and found particular aspects which fitted with my own perspective, or complemented the data. Weatherhead (2011) recommends initially separating the data into narrative segments. Riessman (1998) gives some guidance on how to recognise these, such as entrance and exit

talk. I created a summary for each transcript, which Murray (2008) suggests can highlight key issues within the text. I then analysed each narrative segment in turn, attending to particular features within the data, including narrative tone, characters, imagery, and themes (Crossley, 2000). I also considered the "underlying beliefs and values" (Murray, 2008, p. 120) of the narratives.

Having made these decisions regarding the analysis, I enjoyed the process. The approach allowed a degree of freedom which enabled me to explore aspects such as key characters, the language used, and links to societal discourses. However, this proved more difficult once I began the analysis across transcripts, rather than considering each separately. I found it difficult at times to hold all ten participants' stories in mind, and to feel I had captured the key points from each, achieving both the breadth and depth required by narrative analysis (Riessman, 2008).

In order to retain a sense of each participant's story, I decided to include their summary stories as an appendix. Some narrative researchers recommend sending these stories to participants, to invite their validation (McCormack, 2004; Riessman, 1998). However, Sandelowski (1993) argues that reality, and therefore the telling of stories, is fluid. I also considered narratives to be heavily influenced by the listener and the context (Murray, 2008). Seeking participants' validation of the stories seemed contrary to these concepts. I wondered how likely participants would be to openly disagree with their stories, and how any changes would be effected considering the timescale. Consequently, I decided not to send summary stories to participants. I did create a summary of the research to send to participants. This hopefully allowed participants to see the product of their stories, and how their narratives connected to others in similar positions.

**Chapter Five: Personal Impact of the Research**

It is inevitable that any research will impact on the researcher in some way (e.g., Rager, 2005). Due to being closely linked to both the topic and participant group, I identified strongly with some narratives. Several authors recommend using a reflective journal to process a researcher's reactions (Rapley, 2004; Rew, Bechtel & Sapp, 1993). I utilised my journal throughout the research process, including after each interview. There were several aspects which stood out during my reflections, both within my journal and in discussions with peers and supervisors.

Several participants discussed their training course's stance towards personal therapy, and a lack of clarity regarding their expectations for trainees accessing it. They also noted limited opportunities to reflect on their experiences of therapy. This led me to reflect on my own experiences of personal therapy and its integration within my training. I felt a high degree of support from my course regarding personal difficulties, as well as multiple opportunities for reflection and developing self-awareness. However, I realised I had had no formal opportunity to reflect on the mini-CAT experience, and there was perhaps some lack of clarity regarding it. For example, I did not recall any conversations about why there were six sessions funded, or if there were any course expectations for those utilising the resource. I discussed this with my peers, and fed our thoughts back to the course, for consideration with future cohorts.

Another personal impact of the research process was through participants' responses concerning the need for all trainee therapists to access personal therapy. The following is an extract from my reflective diary: "Several participants have said to be a good psychologist, you *have* to have had personal therapy – feeling a bit of pressure that I should have been accessing weekly therapy throughout training!" After completing my mini-CAT sessions, I had thought I would like to access a more exploratory personal therapy later in training, or in

my career. After some interviews I was left feeling somehow inferior, or substandard, for not engaging in regular long-term therapy. Several participants asked me about my own experiences of personal therapy, after the interview concluded. At times I perceived this as checking whether I was "one of them." I also noted that whilst participants spoke negatively about the dichotomy between therapists and clients, there was an emerging sense of "us and them" between therapists who have therapy, and therapists who don't. I explored these reactions within my reflective diary, and realised I held some criticism towards myself for "putting off" accessing therapy, which had connected to some of the participants' responses. I decided not to seek any therapy whilst I was conducting the interviews and initial analysis, as I did not want any new experiences to affect the data. However, I did decide to explore possible options for accessing therapy later in the year.

Participants' descriptions of the stigma of personal therapy for psychologists also impacted my perceptions of the profession. I had not anticipated these narratives; on hearing them, I sometimes vilified the profession for seeming so judgemental and hypocritical. At other times I felt guilty for being part of the professional body described to possess these judgements. This was somewhat alleviated by a sense from participants that they and I were "on the same side." I wonder if I was subconsciously complicit with this, in an effort to distance myself from a profession who considered psychological distress to indicate weakness or failure. Whilst writing my research paper, I became more aware of the potential role of participants' defences within their feelings of shame. Some of the perceived stigma may represent an external projection of their internal feelings, e.g., of self-doubt (Lemma, 2003). That is not to say the stigma regarding seeking therapy is not present, but that some individuals may be particularly vulnerable to this. This helped to reduce any anger I felt, as I acknowledged it is far from a collective attitude held by all clinical psychologists.

## Conclusion

Throughout the research process, I have gained confidence in my own values and abilities as a researcher. The literature review and research paper combined provide substantial implications for therapy training courses. In particular, the findings suggested trainees often experience fear of negative evaluation from their peers and course staff. This can affect their likelihood of disclosing distress, or negative experiences with supervisors. Training courses should consider these dynamics, and possible ways to decrease this power imbalance as it may impact negatively on work with clients. In addition to submitting both papers for publication in peer-reviewed journals, it is hoped these findings will be disseminated through channels such as the Group of Trainers in Clinical Psychology conference.

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# Section Four: Ethics Section

Hannah Wilson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**FHMREC Application Form Version 3**[3]

**Faculty of Health and Medicine Research Ethics Committee (FHMREC)**

**Lancaster University**

Application for Ethical Approval for Research

**Instructions**

1. Apply to the committee by submitting
   - ✓ The University's Stage 1 Self-Assessment Form (standard form or student form) *and* the Project Information & Ethics questionnaire. These are available on the Research Support Office website: **LU Ethics**
   - ✓ The completed FHMREC application form
   - ✓ Your full research proposal (background, literature review, methodology/methods, ethical considerations)
   - ✓ All accompanying research materials such as, but not limited to,
     1) Advertising materials (posters, e-mails)
     2) Letters of invitation to participate
     3) Participant information sheets
     4) Consent forms
     5) Questionnaires, surveys, demographic sheets
     6) Interview schedules, interview question guides, focus group scripts
     7) Debriefing sheets, resource lists
2. Submit all the materials electronically as a SINGLE email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (http://www.lancs.ac.uk/shm/research/ethics/).
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website http://www.lancs.ac.uk/shm/research/ethics. Applications must be submitted by the deadline stated on the website, to:

   Diane Hopkins
   Faculty of Health & Medicine
   B03, Furness College
   Lancaster University, LA1 4YG
   d.hopkins@lancaster.ac.uk

[3] Version 3 is shown here, which includes all approved amendments

5. Attend the committee meeting on the day that the application is considered.

| |
|---|
| 1. Title of Project:<br><br>Clinical Psychologists' Experiences of Accessing Personal Therapy During Training: A Narrative Analysis |
| 2. If this is a student project, please indicate what type of project by ticking the relevant box:<br>□ PG Diploma □Masters dissertation □MRes □MSc □ DClinPsy SRP<br>□ PhD Thesis □PhD Pall. Care/Pub. Hlth/Org. Hlth & Well Being □MD<br>☑DClinPsy Thesis<br>□ Special Study Module (3rd year medical student) |
| 3. Type of study<br>☑ Involves direct involvement by human subjects<br>□ Involves existing documents/data only. Contact the Chair of FHMREC before continuing. |
| **Applicant information** |
| 4. Name of applicant/researcher: Hannah Wilson |
| 5. Appointment/position held by applicant and Division within FHM:<br><br>Trainee clinical psychologist, Division of Health Research |
| 6. Contact information for applicant:<br><br>E-mail: _h.wilson@lancaster.ac.uk_____ Telephone:___ 07508 406193 (research)<br><br>Address:__ C27 Furness College<br>Lancaster University<br>Lancaster<br>LA1 4YG |
| 7. Project supervisor(s), if different from applicant:<br><br>Name(s): __Dr Stephen Weatherhead, Furness College, Lancaster University,<br><br>Lancaster, LA1 4YG_____<br><br>E-mail(s): __s.weatherhead@lancaster.ac.uk_____ |
| 8. Appointment held by supervisor(s) and institution(s) where based (if applicable):<br><br>Clinical tutor and research lecturer at Lancaster University |

9. Names and appointments of all members of the research team (including degree where applicable) [redacted]

**The Project**

**NOTE**: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (maximum length 150 words).

Personal and professional development is a core competency of training for clinical psychologists, as outlined by the British Psychological Society. Personal therapy has been cited as one method for clinical psychology trainees to pursue both personal and professional development, but there has been little research regarding these experiences. Research involving other therapy trainees, including trainee counselling psychologists, indicates that personal therapy can have a range of positive effects, including experiencing 'client' position in therapy, and coping with stresses (Grimmer & Tribe, 2001).

A questionnaire conducted with clinical psychologists in the UK (Nel, Pezzolesi & Stott, 2012) found that the majority of those who undertook personal therapy during their training rated it as an important part of their development. This project aims to build on this research by exploring the experience of clinical psychologists who undertook personal therapy during their training.

11. Anticipated project dates

Start date: _June 2013_____ End date: ___May 2014_____

12. Please describe the sample of participants to be studied (including number, age, gender):

8-12 participants, who will be qualified clinical psychologists of any age and gender, who started their doctorate in 2002 or later.

13. How will participants be recruited and from where? Be as specific as possible.

Information sheets about the study will be sent to course programme offices who have agreed to distribute the information to previous trainees who meet the inclusion criteria.

They will send the information by email to those who are appropriate, requesting any interested parties to return the interest form to the principal investigator, either by email or by post. Information sheets will also be sent to any clinicians who have expressed interest via word of mouth.
If, 4 weeks after sending information to the programme offices to be circulated, the proposed number of participants has not been reached, the project information will also be circulated via mailing lists and research noticeboards such as the British Psychological Society's Division of Clinical Psychology.

14. What procedure is proposed for obtaining consent?

Potential participants will receive the information sheet and if happy to participate, will return the interest form to the principal investigator, by email or by post. A convenient time for the interview will then be arranged. Before the interview begins, it will be checked that the participant has read the information sheet, and any questions will be answered. Participants will then be asked to sign the consent form.

15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.

There is no expectation that any discomfort or danger would be caused by participating in the project. However, there is always the chance that the discussions may be emotive for the participant, and consequently cause some emotional upset. In the unlikely event that this occurs, the interview can be paused or stopped. All participants will be provided with a debrief, which will include contact details for two independent sources of support; The Samaritans, and SupportLine.
With regards to inconvenience, every effort will be made to ensure that the interview is convenient for the participant, including time and location.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, details of a lone worker plan).

Lancaster University and Lancashire Care Foundation Trust lone working policies will be followed. It will be ensured that another individual is aware of the researcher's whereabouts, and expected check in time.

17. Whilst we do not generally expect direct benefits to participants as a result of this

research, please state here any that result from completion of the study.

There will be no direct benefits to participants as a result of this research. However, their responses will help to inform future development of training courses and consideration of personal development during training.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Nil incentives or payments, except for reimbursement of travel expenses up to £10.

19. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data will be collected via interviews, which will be recorded using a voice recorder. Interviews will then be transcribed and anonymised, before being analysed, using narrative analysis. Narrative analysis was selected as it is concerned with the personal experience of participants, and how they have made sense or meaning of those experiences.

20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research protocol, please indicate this and provide a brief rationale/explanation.

A proposal of this research was presented to a panel including service users and peers, at which it was discussed and amendments were suggested.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

All electronic data will be kept on a password protected laptop. Any identifiable data e.g. audio files will be encrypted. Transcripts will be fully anonymised. Any paper records, e.g. consent forms, will be kept in a locked filing cabinet at Lancaster University. Data stored at the University will be destroyed 10 years after completion of the project, or if it is submitted for publication, 10 years after the submission date.

22. Will audio or video recording take place? □ no ☑audio □video

If yes, what arrangements have been made for audio/video data storage? At what point in

the research will tapes/digital recordings/files be destroyed?

The chief investigator will be responsible for the storage and deletion of data, until the project is submitted. After this time, responsibility will be shared between the chief investigator, and a representative of the DClinPsy programme.
Interviews will be recorded using a digital voice recorder. Audio files will be transferred to a password protected laptop within 48 hours, where they will be encrypted. Once the project has been submitted, audio files will be destroyed by electronically shredding them, using AxCrypt.

23. What are the plans for dissemination of findings from the research?

It is anticipated that firstly, the findings will be presented to peers at a University presentation day. Subsequently, the findings will be submitted for publication. There may also be the opportunity to present them at a GTiCP (Group of Trainers in Clinical Psychology) conference. The results will also be submitted as part of the completed thesis.

24. What particular ethical problems, not previously noted on this application, do you think there are in the proposed study?

It could be seen that the researcher may have a vested interest in the research, as they are a trainee clinical psychologist. However, it will be made clear on the information sheet that there is no expectation as to whether participants will express positive or negative views on personal therapy.
There is also the possibility that participants are acquainted with one, or both, of the project supervisors. Participants will be given the option to request that one of the supervisors does not have access to the audio or transcriptions of their interview; this will be indicated on their consent form.
Participant responses will be kept confidential, and only accessed by the chief investigator and project supervisors before they are anonymised. The exception to this would be if participants disclose anything which suggests a danger to the health, safety or well-being of themselves or others. This is explained on the information sheet. It also informs participants that if their responses raise any concerns with regards to anyone's safety, any subsequent actions deemed necessary will be discussed with them. This may include discussing the issues raised with a supervisor, of a safeguarding officer.

Signatures: Applicant:

……..…….....

Date:

…….....

.....

Project Supervisor* (if applicable):

…….....

Date:

…….....

.....

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

# Appendices

## Appendix A: Ethical Approval

LANCASTER UNIVERSITY

Applicant: Hannah Wilson
Supervisor: [redacted]
Department: DHR

08 July 2013

Dear Hannah and [redacted]

**Re: Clinical Psychologists' Experiences of accessing Personal Therapy During Training: A Narrative Analysis**

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542 592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

S.C. Taylor

Sarah Taylor
Secretary, University Research Ethics Committee

Cc Professor T McMillan (Chair, UREC); Professor Paul Bates (Chair, FHMREC)

Research Support Office
Research and Enterprise Services
Lancaster University
Bowland Main
Lancaster LA1 4YT
United Kingdom
Tel: +44 (0) 1524 592002
Fax: +44 (0) 1524 593229
Web: http://www.lancs.ac.uk

## Appendix B: Previous correspondence with FHMREC

Our ref: FHMREC12051

17 June 2013

Hannah Wilson
Division of Health Research
Faculty of Health and Medicine
Lancaster University

Dear Hannah,
Re: FHM Research Ethics Committee application for project titled: *'Clinical psychologists' experiences of accessing personal therapy during training: a narrative analysis'*.

Thank you for sending in the paperwork for your application. We appreciated reading about the project. We have a few minor concerns, and ask that you address the following in revising your application materials:

- **Application section 22**
  - Please indicate in this section who will be responsible for the storage and deletion of data once you have completed your course.
  - We suggest that you wait until your project has been submitted before destroying the original recordings, and amend this section accordingly.
- **Application section 24**
  - Please state here the circumstances in which you may have to break confidentiality (that is the 'limits to confidentiality', when you view that a participant has indicated they may cause harm to themselves or others).
- **Protocol**
  - **Procedure (p.21).** 1) Please clarify what will happen once the information sheets have been sent out. 2) clarify how the expression of interest form will be completed and returned to you.
  - We suggest you consider staggering the first and second methods of recruitment, to reduce the chance of over-recruiting.
- **Practical issues (p.23).**
  - The University's policy is now to keep all data for 10 years after study completion.
- **Participant Information Sheet**
  - Amend the opening sentence, such that it is clear you're undertaking research for your thesis or as part of your thesis. The thesis itself is just the final product.
  - **What will happen to the information I give?** Include here information regarding the circumstances in which you would have to break confidentiality (harm to self or others), noting what you will do.
  - **Is participation compulsory?** Given the form of analysis proposed, the approach to withdrawal seems inappropriate. We suggest offering open-ended withdrawal up to the point of the project being written up.
- **Consent form**
  - Please amend the format in line with the exemplar given on the FHMREC webpage:
  - Change contact details to say 'clinical psychology'

Physics Building
Lancaster University
[illegible]

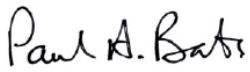
Tel +44(0)1524593169
Fax +44(0)1524592650
Email: [illegible]@lancaster.ac.uk

Professor Tony Cattell
Dean of Faculty

**In addition to the above a number of minor changes and typos are noted on your application form, attached with this letter. Please address these, as well as the matters above.**

Ensure consistency between the application form, the Research Protocol and the supporting materials in line with the changes requested above.
Please use Lancaster University letter-headed paper for all participant materials
We ask that you attend to these in writing by (re)submitting to the FHMREC via Diane Hopkins (d.hopkins@lancaster.ac.uk) the application document and materials with any changes highlighted.
If your responses to the above are satisfactory then approval will be recommended on Chair's action. If you have questions, please feel free to contact me.

Yours sincerely,



Prof Paul Bates
Chair of the Faculty of Health and Medicine Research Ethics Committee
Lancaster University

## Appendix C: Protocol

# Clinical Psychologists' Experiences of Accessing Personal Therapy During Training: A Narrative Analysis

Principal Investigator: Hannah Wilson, Lancaster University
Field Supervisor: [redacted]
Academic Supervisor: [redacted]

## Introduction

In 2002, the British Psychological Society (BPS) added 'Personal Professional Development' as a core competency of clinical psychology training programmes. Personal therapy has been cited as beneficial in both personal and professional development (Sheikh, Milne & MacGregor, 2007), yet there is no agreement on whether it should be facilitated for clinical psychology trainees.

For some trainees in similar professional areas, e.g., counselling psychology and psychotherapy, personal therapy is a mandatory training requirement.

Research with therapy trainees from outside clinical psychology, has shown a variety of benefits which personal therapy can yield (e.g., Daw & Joseph, 2007; Holzman, Searight & Hughes, 1996; Kumari, 2011; Macran, Stiles & Smith, 1999; Moller, Timms & Alilovic, 2009; Murphy, 2005; Rizq & Target, 2008). Grimmer and Tribe (2001) reviewed the literature and grouped these benefits into six main categories: Increased emotional and mental functioning for the therapist; a more complete understanding of personal dynamics and potential conflictual issues; alleviating emotional stresses and burdens; a socialisation experience; placing therapists in the role of the client; and observing clinical methods, including the opportunity to decide what *not* to do once qualified.

The majority of empirical evidence suggests that therapists who undertake personal therapy during training find it useful. However, most studies have failed to show any positive effect on outcomes of therapy, when it is delivered by those who have received therapy themselves (Clark, 1986; Macran & Shapiro, 1998). Gold and Hilsenroth (2009) did find some significant differences in therapists' self-ratings of outcomes, between those who had and hadn't had personal therapy; however, these differences were not echoed in client ratings.

Personal therapy may affect therapy outcomes in ways not measured in previous studies. Differences in the therapist's perspective may affect the therapeutic alliance, and consequently the course of therapy. Therapists who have received personal therapy may be more able to recognise when their own relational traps are activated, within therapy they are delivering. They can then acknowledge and process this before any potential damage to the therapeutic relationship occurs.

Personal therapy may also increase therapists' ease of empathy with clients, having experienced a similar position. This may, in turn, help clients to feel understood by their therapist.

It could also be argued that therapy outcome is not the only way in which personal therapy could be of benefit. By providing a way to deal with stressors, therapists' own resilience may be enhanced. This may consequently reduce the risk of "burn out," or time off work due to stress.

To date, there has been little research within the UK regarding personal therapy for clinical psychologist trainees. There has been greater exploration of the topic with counselling psychology trainees, but the decision to undertake personal therapy may be driven by different factors in the two populations.

For counselling psychology trainees, personal therapy is mandatory. Trainees are required to fund it themselves, as well as paying large sums for their training. In comparison, the majority of clinical psychology doctorate courses do not provide personal therapy, although many will provide trainees with support or advice in accessing it. Clinical psychology trainees also receive a wage, and are not required to fund the course. Consequently, personal therapy may not be as great a financial burden, and generally has to be actively sought by clinical psychology trainees. These differences may affect trainees' expectations for therapy, the way in which it is experienced, and their perspective of whether it was beneficial or otherwise.

Nel, Pezzolesi and Stott (2012) conducted a survey of 357 clinical psychologists within the UK, and found that 26% had been exposed to personal therapy during their training. Of those, 88% rated it as either important or very important in their development. One participant wondered "how can you deliver therapy without experiencing it?" This sentiment was supported by a study conducted with service users (Youngson, Hames & Holley, 2009), in which the majority emphasised the importance of personal development of clinical psychologists, which may be aided by undertaking personal therapy. One service user stated, "if they [psychologists] are not mindful of themselves and are unfamiliar with their

own emotional landscapes how on earth can they help someone try to understand theirs? It would be like the blind leading the blind" (p. 72).

Considering the lack of research with clinical psychologists on this topic, and the absence of a unified perspective on personal therapy during training, it is both pertinent and important to build on the results from Nel, Pezzolesi and Stott's (2012) questionnaire; in order to gain a better understanding of the way in which personal therapy is experienced by clinical psychologists in training, and its effect on their personal and professional development.

## Method

### Participants

The study aims to recruit approximately 8-12 participants to the project. Participants will be qualified clinical psychologists, who began their doctorate in clinical psychology in 2002 or later, within the UK. In 2002, the BPS introduced 'personal and professional development' as a core competency of clinical psychology training, therefore it was felt that those who were training at, and after, this date, were more likely to have had access to personal therapy facilitated or encouraged. Consequently, those who began their training in 2002 or later will be contacted for participation.

### Design

A qualitative design involving semi-structured interviews is to be followed, with interviews taking place in person. The study aims to explore the experiences of clinical psychologists who accessed personal therapy during their training.

### Materials

A semi-structured interview schedule will be followed during the interviews; this will consist of open questions and topic areas as prompts, designed to address the research questions but also allow space for conversation and narratives to develop. Interviews will be recorded by a digital recorder. Materials created for participants, such as the information sheet, can be viewed in the appendices of this document.

### Procedure

Recruitment will follow a two-staged approach, and is demonstrated in Figure 1. Firstly, clinical psychology doctorate course centres who have agreed to circulate the information to their previous trainees will be sent the information sheet and interest form (see

appendices A and B), to forward to all trainees who have qualified from that course, and began their training in 2002 or later. It is expected that the information sheet will be sent to interested courses via email, and similarly forwarded by email, however if courses indicate that they would prefer to receive it by post, and/or send it by post, this will be facilitated. Clinicians who are interested in taking part will be required to return the interest form, either by email or by post, to the chief investigator. In addition to the courses circulating details, the information sheet and interest form will be sent, either electronically or via post, to any clinicians who have professed an interest in the study through word-of-mouth.

If, four weeks after sending information to the doctorate courses to circulate, required participant numbers have not been reached, the information sheet and interest form will be sent to clinical psychologists via mailing lists and research noticeboards, such as the British Psychological Society's Division of Clinical Psychology. They will also be advertised on www.clinpsy.co.uk, which is a website forum for clinical psychologists and often features research projects.

If more than the required number of participants indicate an interest in participating, selection of participants will take place according to several factors. These include the model of therapy they experienced and length of therapy (in order to have a diverse range of participant experiences), and logistics, such as travel time to the participant's location. If these factors are similar amongst potential participants, they will be selected randomly, by assigning each potential participant a number then using a random number generator (http://www.random.org/) to select participants.

Any individuals who have professed an interest in participating but are unable to take part will be thanked for their interest, and informed that they will not be interviewed at this point. This contact will be via email if possible, otherwise by post or telephone if they have indicated a preferred method.

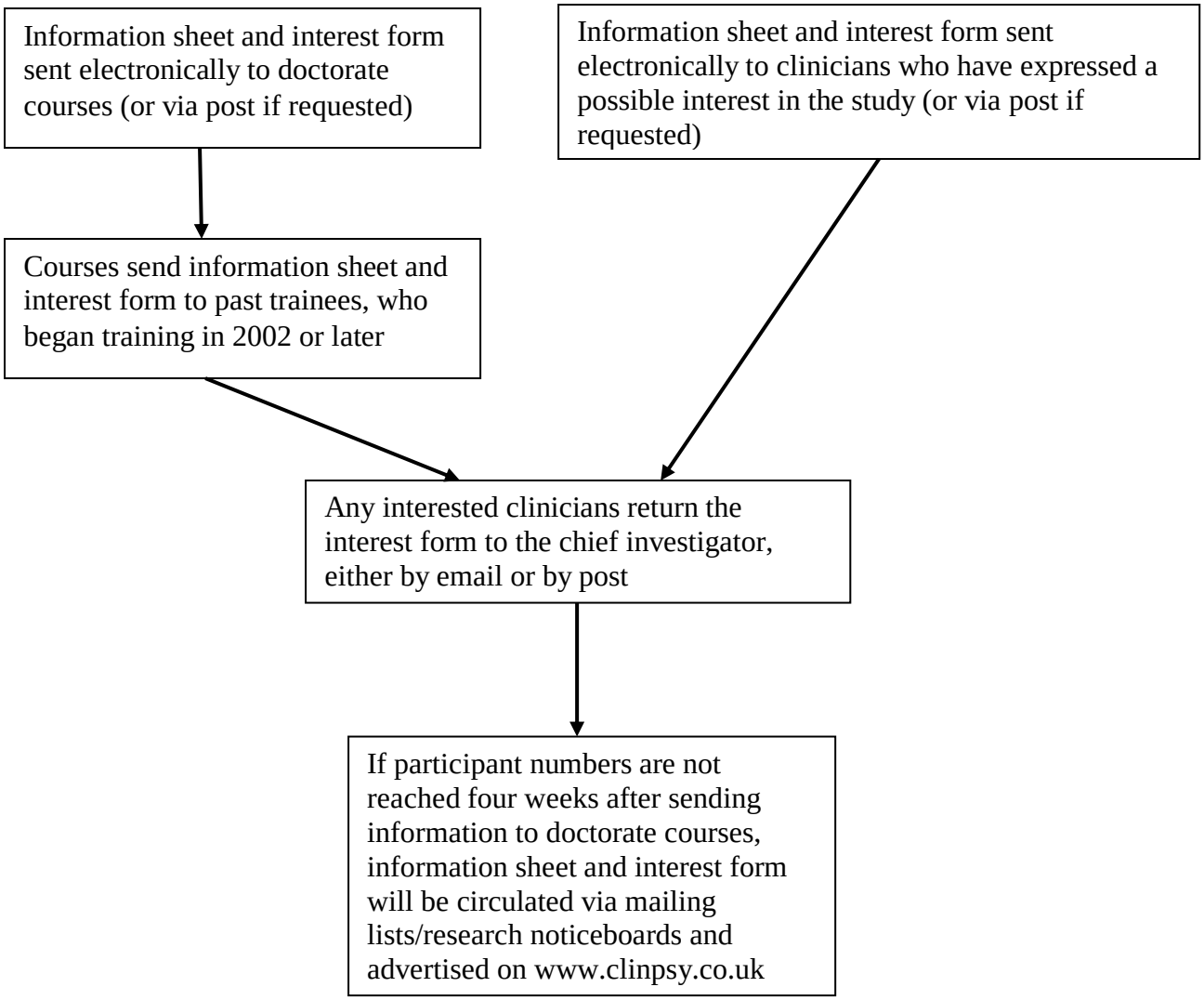



Figure 1: A Flowchart to Demonstrate the Recruitment Procedure

Once clinicians have been identified for inclusion, an appropriate time and place for the interview will be decided with the participant. The Lancaster University and Lancashire Care NHS Foundation Trust lone worker policies will be followed. It will be ensured that another individual is aware of the researcher's intended location and check in time. Potential locations for the interviews include: Lancaster University; participants' homes; and participants' place of work, providing there is local agreement.

Before the interview begins, any questions will be answered. If the participant is happy to proceed, they will be asked to sign the consent form. After the interview, the participant will be given a debrief sheet and any further questions will be answered.

The interview will be recorded using a digital recorder, and all recordings will be encrypted and stored securely on a password protected laptop. The principal investigator will

transcribe each recording and ensure they are fully anonymised. Transcription of the recordings will take place within 6 weeks of the interview. Recordings will be deleted after the project is submitted.

## Proposed analysis

The data collected will be analysed using narrative analysis. Narrative analysis generally focusses on the personal experience of participants, as expressed through narratives, or stories. It adopts the position that both personality and identity are built through narratives (Wertz et al., 2011). Squire (2008) describes an experience-centred approach to narrative analysis, which "assumes 'personal narrative' includes all sequential and meaningful stories of personal experience that people produce" (p. 42). Consequently, all information provided within the interview is examined, including silences, and the organisation of a narrative (Riessman, 1993).

During the analysis, common threads and stories across the interviews will be drawn out, through reading each transcript several times and exploring the narratives within. Mishler (1986) stated that any narrative analysis must consider the three main areas of linguistics, when examining participants' stories: structure; meaning; and context. This includes considering the choices made by participants in what they say, and when they say it, as well as the way in which they make links between different aspects of their experiences.

Both the research and field supervisors will potentially have access to the recordings of interviews, in order to help with development of the researcher's interviewing skills. They will also have access to transcripts of the interviews, to aid with validation of analysis.

## Practical issues (e.g., costs/logistics)

All electronic data will be stored securely on a laptop, protected with a password and encrypted. Photocopying costs of consent forms and debrief sheets will be met by Lancaster University Doctorate in Clinical Psychology Programme.

If participants choose to be interviewed at Lancaster University, then travel expenses will be reimbursed up to £10, provided valid receipts/mileage estimates are supplied.

Any paper data, e.g., consent forms, will be stored at Lancaster University, in a locked filing cabinet, until 10 years after the study has finished at which point it will be destroyed. If the study is submitted for publication, then data will be kept for 10 years after the point of submission. Up to the point of submitting the project, responsibility for the storage and deletion of data will rest with the chief investigator. After the project is submitted, this

responsibility will be shared between the chief investigator and a representative of the Lancaster University Doctorate in Clinical Psychology.

## Ethical concerns

Although not anticipated, there is the possibility that the topic of the interview schedule may be an emotive subject, and consequently may distress some individuals. Should a participant become upset, the researcher will offer to pause the interview for a break, and ask whether the participant would like to discuss anything about the interview, or what has led them to feel distressed. If the participant remains upset, the researcher will offer to terminate the interview, or where possible continue at a later date. All participants will be debriefed to minimise any lasting distress. The researcher will offer details of independent available support resources; The Samaritans and SupportLine.

There is the possibility that some participants may have some familiarity with the supervisors. All participants will be given the option to request that one of the supervisors does not have access to the transcript of their interview, but at least one supervisor will need to be able to review it.

It may be that the initial email and information sheet is sent to a workplace email, including NHS email, or that participants would like the interview to be conducted at their place of work. When potential participants are contacted to arrange participation, they will be asked to ensure that any relevant local R&D requirements are adhered to.

## Timescale

The final deadline for the report is May 2014. Once ethical approval is granted, recruitment will begin. Data will then be analysed and the report will be produced.

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**Appendix D: Participant Information Sheet**

## Participant Information

I am a trainee clinical psychologist at Lancaster University, and am currently undertaking research for my thesis, entitled "Clinical Psychologists' Experiences of Accessing Personal Therapy During Training: A Narrative Analysis." I would like to invite you to take part in my project; below are some details about the research, and what participation would involve. If you have any questions about it, please contact me using the details at the end of this document.

**Background to the study**

Although personal and professional development is actively encouraged within clinical psychology doctorate programmes, there is a wide variance between programmes with regards to whether personal therapy is facilitated, or encouraged, during training.

**Aims of the research**

This project aims to explore the process of personal therapy, and its effect on both personal and professional development, by interviewing qualified clinical psychologists who undertook personal therapy during their doctorate training.

**What does it involve?**

I am hoping to talk to qualified clinical psychologists, who accessed personal therapy during their training. This would involve participating in an interview about your experiences, which would take approximately 60 minutes.

The interviews will be recorded using a voice recorder, then later transcribed. Only my two supervisors and I will have access to the recordings and transcripts. Once the project is submitted, the recordings will be deleted. The transcripts will be anonymised, as will any quotes used from the interviews within the thesis write-up. This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University.

In order to find participants for this study, this information is being circulated by various clinical psychology programmes, and mailing lists such as the British Psychological Society's Division of Clinical Psychology. Consequently, it may be that not all psychologists who are interested in taking part are able to be interviewed. If you contact me regarding participation, and I am unable to interview you, then I will inform you that this is the case.

**Who can take part?**

There is no clear definition of "personal therapy," as there are many factors which can vary between experiences of "therapy." To participate in the study, you must have experienced some form of personal therapy during your clinical psychology training. It doesn't matter what model or approach the therapy followed, how many sessions you received, or how the therapy was funded. In addition to this, you must be a qualified clinical psychologist, who began their training in 2002 or later.

**Is participation compulsory?**

No. Participation is entirely voluntary. If you are happy to participate in the study, you will be asked to complete a consent form. You are able to withdraw from the study at any point until the project has been written up.

**What are the possible benefits of taking part?**

Taking part in the study won't necessarily have any direct benefits, or change anything, for you. However, your responses could help to shape the way in which personal therapy is considered as part of clinical psychology training.

**What are the possible risks of taking part?**

The interview is not designed to be stressful or upsetting. However, if you feel that you need a break, the interview can be paused until you feel able to continue, or the interview can be terminated if you wish. I will provide you with details of people who you can talk to if you feel upset or would like some additional support.

You may be concerned about disclosing any negative experiences of personal therapy, both of the therapy itself or your course's role in facilitating it. There are no expectations about whether participants will have found personal therapy to be a helpful or unhelpful experience.

**What will happen to the information I give?**

Any identifiable information (e.g., your consent form) will be kept securely. The recordings of the interviews will be transcribed and anonymised. They will be reported in a thesis, and may be submitted for publication in an academic or professional journal. Consent forms, transcripts, and any other identifiable data, will be stored securely at Lancaster University, and destroyed 10 years after the end of the study or following publication.

Only I, and my supervisors, will have access to your responses before they are anonymised. The only exception to this would be if you describe something which may be a danger to the health, safety or well-being of yourself or others. If you disclose something which suggests that you, or someone else, are at risk of harm, then I will discuss this with one of my

supervisors. If any further actions are necessary, I will discuss it with you first; this may include contacting a safeguarding team or social services.

You may have previously had contact with either, or both, of the project supervisors. They are the only other people who will have any access to your interview, and they will not pass on any information to anyone else. All participants will be given the option to request that one of the supervisors does not have access to their recording or transcript. However, one supervisor must have access, as they will help in reviewing the interviews and developing the results.

**What now?**

If you have any questions, please contact me using the details below and I will do my best to answer them. If you would like to take part in the study, I would be grateful if you could return the attached interest form, either via email or post, as per my contact details below. I will then be in contact, to arrange a convenient time for the interview.

**Where can I obtain further information about the study if I need it?**

If you have any questions or concerns about the study, I will do my best to answer them. My contact details can be found at the bottom of this information sheet.

**Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Craig Murray
Acting Research Director
C17 Furness College
Lancaster University
LA1 4YG
c.murray@lancaster.ac.uk
01524 592730

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor Paul Bates
Associate Dean for Research
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YD
p.bates@lancaster.ac.uk

(01524) 593718

If at any time you have any questions or concerns, please contact me on the address or telephone number below.

Thank you for taking the time to read this.

Best wishes,

Hannah Wilson
Trainee Clinical Psychologist
C27 Furness College
Lancaster University
Lancaster
LA1 4YG

h.wilson@lancaster.ac.uk
07508 406193

**Appendix E: Interest Form**

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## Interest Form

I am happy to take part in this study and for you to contact me to arrange a convenient time and place to meet.

Name: _____

Contact details:_____

_____

Please could you also provide the following details regarding the personal therapy you experienced during your clinical psychology training:

Number of sessions received: _____

Model/approach of therapy: _____

Funding source for therapy: _____

Stage of training when received therapy: _____

University attended for training: _____

Years on the doctorate in clinical psychology (e.g., 2006-2009): _____

Principal Investigator:
Hannah Wilson

Department of Clinical Psychology
C27 Furness College
Lancaster University
Lancaster
LA1 4YG
h.wilson@lancaster.ac.uk
07508 406193

ETHICS SECTION

**Appendix F: Consent Form**

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## Consent Form

**Title of study:** Clinical Psychologists' Experiences of Accessing Personal Therapy During Training: A Narrative Analysis

**Principal Investigator:** Hannah Wilson

**Contact details:**

Department of Clinical Psychology
C27 Furness College
Lancaster University
Lancaster
LA1 4YG
h.wilson@lancaster.ac.uk
07508 406193

***Please tick each box***

- I confirm that I have read the information sheet and fully understand what is expected of me within this study ☐
- I confirm that I have had the opportunity to ask any questions and to have them answer ☐
- I understand that my interview will be audio recorded and then made into an anonymis written transcript. ☐
- I understand that audio recordings will be kept until the research project has been submitted. ☐
- I understand that my participation is voluntary and that I am free to withdraw at any tin without giving any reason, up to the point that the project is written up. ☐
- I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. ☐

- I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
- I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with her research supervisor. ☐
- I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐
- I consent to take part in the above study. ☐

The following clinicians are supervising this project, and consequently may have access to the recording or transcript of your interview. It may be that you know one of them, and do not feel comfortable with them accessing your interview. If this is the case, please place a cross in the box below to indicate which supervisor you do not want your interview shared with. At least one of the supervisors must have access to your interview, to help maintain the quality of the interviews and aid development of the results.

[redacted] ☐

[redacted] ☐

Name of participant:

_____

Signature of participant:

_____

Signature of researcher:

_____

Date: _____

## Appendix G: Interview Schedule

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### Introduction

- Introduce self, provide copy of info sheet if requested (already seen once) and consent form
- Discuss recording and anonymity – ask them to choose a pseudonym
- Discuss confidentiality, including limits
- Answer questions & sign consent form
- Ask if they would like either supervisor not to hear/see their interview – ensure corresponding box is checked on the consent form
- Check whether participant would like to receive the research summary, once the project is completed – if so, electronically or via post

### Opening question

I'd like you to tell me about your experience of personal therapy during your clinical psychology training. This can include any events or decisions during the process which were important for you. Start wherever you like with your story of this experience, and we'll go from there.

### Further prompts

- Why/how sought therapy
- Selection of therapist
- Expectations of therapy – were they met
- Experience of sessions
- Anything surprising/unexpected
- Impact on self – personal & professional
- Gains/positives
- Negatives
- Reason for ending therapy
- Impact of therapy
- Reflections on the process & timing
- Recommend therapy to trainees?

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## Appendix H: Debrief Sheet

**Debrief**

Thank you for taking the time to participate in my study. I am grateful for your time, and for you sharing your experiences with me. Although I hope this is not the case, speaking about your experiences of personal therapy may have meant that you revisited some difficult or emotional memories. If you would like to speak to me about any of your feelings after this interview, please feel free to contact me on the details below. Alternatively, I have also provided the details of some independent organisations who you can contact for additional support.

**My contact details:**

Hannah Wilson
Department of Clinical Psychology
C27 Furness College
Lancaster University
Lancaster
LA1 4YG
h.wilson@lancaster.ac.uk
07508 406193

### Other contacts:

The Samaritans: call 08457 90 90 90 or email jo@samaritans.org. Samaritans is a confidential emotional support service for anyone in the UK and Ireland, and is available 24 hours a day.

SupportLine: call 01708 765200, go to http://www.supportline.org.uk/index.php or email info@supportline.org.uk. SupportLine offers emotional support to people of all ages.