

Portfolio Volume 1: Major Research Project

Trainee Clinical Psychologists' Experiences of  
Personal Therapy and Its Relationship to Development  
Across Training: A Grounded Theory Study

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<sup>1</sup> Appendices O,P,W,X removed to ensure anonymity

## ABSTRACT

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Although it is not a professional requirement, research shows that some Trainee Clinical Psychologists (CPs) access PT (PT) whilst training (Nel, Pezzolesi & Stott, 2012). CPs' practice is moving towards the Reflective-Scientist-Practitioner Model, therefore identifying ways that CPs may develop reflective skills is required. Most other therapeutic trainings have PT as a requirement (Malikiosi-Loizos 2013), which is suggested as a method of developing reflective skills (Lavender, 2003; Wigg Cushway & Neal, 2011). Little research has investigated the use of PT by Trainee CPs. The current study explored processes by which 12 Trainee CPs experienced their own (PT), and how these processes related to their development whilst training. Participants were interviewed using single, semi-structured interviews. Data was analysed using Constructivist Grounded Theory (Charmaz, 2014). Two models were constructed, these described participants' decision to access PT mediated by anticipating or experiencing distress and learning about the self through PT. Participants seemed to develop and learn about themselves in three domains; 1) Learning about me: Personally; 2) Learning about me: Professionally; and 3) Learning about me: Being a client. I understand this development occurred through the continuous process of participants taking a dilemma to PT, reflecting upon the dilemma, and thereby acquiring a different understanding of themselves. These experiences apparently permit participants to integrate personal attributes into their professional identities and to model positive experiences from their own therapy in their practice. The results support PT as a method of developing competencies required within the Reflective Practitioner Model, implying that the use of PT for Trainee CPs should be considered within professional training. Furthermore, participants described emotional struggles during training which they perceived, according to professional discourses, to be unacceptable. This implies that evaluating formal and informal support systems for Trainee CPs is essential.



### **1.1 Overview**

This study aims to explore the processes by which Trainee Clinical Psychologists experience their own Personal Therapy (PT), and how these processes may relate to their development whilst training. The chapter provides a background to the project, beginning with my epistemological and personal position. Literature on the current context of clinical psychology training and models of training in the UK are then discussed, the relevance of reflective practice to current models of training is considered, and a discussion of how these aspects of the model may relate to the use of PT is presented. Literature on the role of PT to psychological therapists is then briefly considered. A systematic literature review is then presented, providing a critical synthesis of literature evaluating Trainee Clinical Psychologist's use of PT, and how it may relate to their practice. Gaps in current understandings of the role of PT to Trainee Clinical Psychologists are discussed, and a rationale for the clinical relevance and aims of the project are presented.

### **1.2 My Position**

#### **1.2.1 Reflexivity**

In line with Finlay (2002), it is my view that as a qualitative researcher my own experiences and perspectives will influence all aspects of this research. Reflexivity in the form of critical self-reflection and transparency is therefore offered throughout. I hope that this will allow the reader to assess the impact that my perspectives and experiences have on all aspects of the research process. Moustakas (1990) describes a process whereby a researcher's interest in a topic is magnified if the research concurs with their personal experiences. This is the case with this research and therefore I would like to begin by briefly introducing my position and relationship to the research.

#### **1.2.2 My epistemological position**

My personal epistemology (Bateson, 1979) was constructed and embedded in my understanding of the world before I had a comprehension of its meaning. Having a socialist mother and growing up within a feminist family system first exposed me to the idea that all experiences were socially constructed. Despite temporarily resisting this philosophy, it served me well in my academic

pursuits in sociology and politics, and ultimately led me to complete my clinical psychology training at the University of Hertfordshire (UH), a course aligned with this philosophy. My epistemological position is influenced by continued questioning of the nature of knowledge, and an identity constructed and re-constructed via experiences, interactions and discourses at various junctures in my life. This has led me to a social constructionist position, one which emphasises the socially interactive basis by which knowledge is shaped and re-shaped through discourse (Charmaz, 2008), and in which realities are constructed through interactions in the social world (Burr, 1995; Gergen, 2009).

Social constructionism forms the basis for this study and it is my belief that the research reflects a co-construction between my participants and me, situated within the social contexts of our interactions and my interpretations. This position is inconsistent with positivist notions of truth and knowledge as objective. The research is therefore interpretative and represents my own story of participants' experiences. Social constructionists argue that we all form our own picture of events according to our past and present experiences (Steier, 1991); I therefore move on to consider my relationship to this research, offering reflections on my journey to it.

### **1.3 The use of Language and Terminology**

In line with my epistemology and the idea that my beliefs and values impact on the research, I use first person pronouns throughout. I hope that this will prevent distancing myself from the research process (Crotty, 1998).

#### **1.3.1 Terminology**

Key terms used throughout the research will be outlined for clarity of understanding. The term 'psychological therapist' is used to refer to mental health professionals working therapeutically with clients. A Clinical Psychologist (CP) is a mental health practitioner working with individuals, groups and systems, to reduce psychological distress by applying knowledge derived from psychological theory and data (BPS, 2015). Throughout the research, PT (PT) is referred to as a mental health practitioner's own psychological therapy, by means of any theoretical orientation or format (Norcross & Guy, 2005).

The role of PT to Trainee CPs' personal and professional development across training is considered within this research. The Oxford Dictionary describes development as a specified state of growth or advancement (Development, 1999). Many definitions of both personal and professional development have been proposed. For the purpose of this study, personal development is conceptualised using Gillmer and Marckus' (2003) definition, as this definition is proposed in relation to CPs in training. The authors describe personal development as the part of training that assists Trainee CPs to develop critical reflection capabilities regarding the work-self interface. They suggest that this process helps Trainee CPs to develop self-awareness and resilience. Professional development is defined using Elman, Illfelder-Kaye and Robiner's (2005) definition, as it is related to professional psychology (Woodward, Kelville & Conlan, 2015). The authors define professional development as the process of obtaining, increasing, refining and sustaining knowledge, skills, and qualifications related to professional functioning and practice.

Internationally, the role of CPs varies significantly. Therefore I begin the literature review with an overview of the role of clinical CPs and the development of the profession in the UK.

### **1.2.3 My personal journey**

In September 2014 I started clinical psychology training at UH. My journey to training is interlinked with my relationship to PT. I experienced both personal and family therapy in Child and Adolescent Mental Health Services (CAMHS), and periodically returned to therapy in adulthood, at times when my emotional wellbeing was fragile. The desire to replicate this support, and to understand and make sense of my experiences, propelled me through my journey to training.

I began training with an understanding that this would be a time of significant personal development. However, I had not anticipated how conflicted I would feel about positioning myself within a professional, "expert" role, whilst trying to work out how to incorporate my past and myself into this position. At the same time, the experience of training heightened my awareness of myself, exposing patterns of relating that I had been unaware of. This led me to contemplate returning to therapy, but ultimately the catalyst for returning was being unable to make sense of difficult feelings for a client. My decision to use PT whilst training was partly to try and resolve

my own identity dilemmas, whilst also endeavouring to better understand dynamics within the therapeutic relationship.

In the second term of my first year of training, I embarked on psychoanalytical psychotherapy. At times I found this extremely painful, as I struggled to cope with the emotions unearthed by this exploration whilst simultaneously managing the demands of training. At the end of the first term of my second year, I withdrew from therapy, as I became overwhelmed. With little guidance on how to make sense of this experience, I chose to focus my research on understanding how others may have experienced PT during training.

The process of interviewing participants for this study inspired me to return to therapy. The emotional struggles experienced by participants resonated with me, functioning to partially normalise my own difficult experiences, and to remind me of the benefits of using therapy whilst training. This very tangible example of participants' narratives influencing my behaviour increased my awareness of my potential impact upon participants and the stories they chose to tell. This was a timely reminder to remain curious but neutral, enabling me to be more open to hearing what my participants were saying.

I am unsure as to whether PT has made me a better clinical psychologist, however it has increased my awareness of how my history impacts on my conduct in relationships, particularly within clinical work. It has also helped to develop my understanding of transference and counter-transference and how to discuss this in supervision. My position is that it has been a tool to support my development, both inside and outside of training, which at times has been a painful one. I offer this understanding of my own journey, to acknowledge how my story may impact upon how I see and make sense of other people's experiences.

#### **1.4 Literature Review**

This brief background aims to introduce the reader to the training roles and models of CPs within the UK context, focussing on the move from scientist-practitioner to reflective-scientist-practitioner models of training. The role of reflective practice and its relation to Personal and Professional Development (PPD) within the profession is considered, and the reader is briefly

introduced to literature supporting the idea that PT may be one way of developing reflective capacities. The relevance of PT to the profession of CPs and clinical training is then considered through a discussion of the literature on therapists' use of PT. It is beyond the scope of this review to provide a detailed understanding and critique of this research, and so key findings of two review papers synthesising available data is presented and critically discussed. A systematic literature review regarding Trainee CPs' experiences of PT whilst training is then presented. Finally, the rationale for why the proposed research would be of benefit is provided, and the research questions are presented.

#### **1.4.1 Clinical Psychology: The UK Context**

In order to discuss the role of PT in CP's training, it is important to define their role. The British Psychological Society (BPS, 2015) outlines ten overarching competencies that Trainee CPs must develop across training to qualify for chartered membership. These include: the development of skills, knowledge and values relevant to direct and indirect working with specific client groups; to competently complete psychological assessments, formulations and interventions with clients, and to evaluate these; to be able to engage with a multitude of professionals who may be relevant to clients' care from both statutory and non-statutory services; to maintain a professional and ethical value base; and to complete all work within a reflective scientist-practitioner model, including having a high level of skill in managing personal learning, self-care, critical reflection, and self-awareness (BPS, 2015).

Professional training is achieved through a combination of academic, clinical, and research activity, taking place through: supervised clinical practice within the National Health Service (NHS), teaching, and completion of a doctoral thesis (Nel, Pezzolesi & Stott, 2012). The doctoral programme aims to train CPs who meet the aforementioned competencies. There are now 30 doctoral programmes in Clinical Psychology in the UK. In 2016 there were 3730 applicants for 595 places, amounting to an applicant success rate of 16% (Clearing House for Post Graduate Courses in Clinical Psychology 2016; 2016 Application Statistics). The competitive nature of the process of training, arguably may impact on how Trainee CPs respond to the training experience. Research suggests high levels of stress in Trainee CPs during training, with estimated prevalence rates of distress, as measured by the General Health Questionnaire, being 59% (Cushway, 1992).

On the Clearing House website, doctoral courses describe support mechanisms that are in place for Trainee CPs (Clearing House for Post Graduate Courses in Clinical Psychology, 2016, Courses), arguably suggesting that support may be necessary and acknowledging that training may bring with it manifestations of distress.

Contemporaneously, PT is not a mandatory requirement for Trainee CPs in the UK. The BPS Division of Clinical Psychology (DCP) website states that PT is not mandatory for CPs ([www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/personal-therapy](http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/personal-therapy)). It argues that the difference between Counselling Psychologists (where PT is mandatory) and CPs is largely due to the historical routes and foundation upon which the Clinical Psychology training programmes were developed, as well as the varied role of CPs compared to Counselling Psychologist's, who primarily work as therapists (Duncan, 2012; Wilson, Weatherhead & Davies, 2015). It has also been argued that the culture of the profession may impact on discussions of the relevance of PT to the profession (Davidson & Patel, 2009), these factors will now be considered.

#### *1.4.1.1 The scientist –practitioner model.*

The scientist-practitioner model was developed in the US at the Boulder Conference on Graduate Education in Clinical Psychology in 1949, in response to a need for a coherent model for professional psychology in the US (Baker & Benjamin, 2000). It was decided here that PT should not be mandatory for training CPs, as there was no clear evidential basis for its relevance to practice (Baker & Benjamin, 2000). The model was soon incorporated into professional psychological practice in the UK (Lavender, 2003). Consequently, in the UK Clinical Psychology has developed as an academic, scientific discipline, built and developed upon positivist notions of truth and reality (Pilgrim, 2010). The model holds that a “scientific approach should inform all of the work of Clinical Psychologists” (Shapiro, 2002, p. 234). Central to this model is bridging the gap between research and practice, so that research informs all practice, but that practice may also inform new research and developments (Beinart, Kennedy & Llewelyn, 2009). The model views therapeutic techniques as the application of academic skills to clients, whose presenting difficulties are seen in relativistic terms (Rake, 2009)

Thomas (2004) has suggested that working within this framework encourages professionals and Trainees to perceive themselves as free from inner struggles and detached from the emotional pain of clients. Ergo, it is unsurprising that PT has not historically been considered essential to the practice of CPs. The culture of the profession within the context of this model will now be considered.

#### *1.4.1.2 The culture of clinical psychology.*

Some evidence suggests that experiences of psychological distress may be common amongst CPs, and that as a professional group CPs are more likely to have been exposed to aversive childhood experiences compared to the general population (Aina, 2015; Duncan, 2012). These ideas concur with the ‘wounded healer’ paradigm, which suggests that individuals experiencing psychological wounds may come to the profession as a method of drawing on their own wounds to assist the healing of others (Jackson, 2001). It is suggested that the more a wounded healer understands their own wounds, the better able they may be to guide others through this process (Gelso & Hayes, 2007). This would suggest that it is important for Trainee CPs to be able to reflect on their own experiences of distress so that they may be better able to help others.

However, it is suggested that experiences of personal distress are challenging to discuss within training and practice (Aina, 2015), and this may be related to the profession’s culture. Davidson and Patel (2009) have suggested this may be because of an endemic rhetoric that in order to practice clinically CPs should be immune to psychological difficulties. Richards (2010) talks of the distinction between ‘us’ and ‘them’ within mental health settings, propagating the idea that individuals seeking support are somehow different to others and certainly to the professionals they visit. The desire, or perceived need, to engage with PT may suggest psychological vulnerability, or movement towards the position of client. It seems that whilst the profession distances itself from the idea that CPs may experience distress, open discussion and consideration as to the relevance of PT within the profession may be difficult. However, the UK’s training model has shifted in recent years, bringing reflection to the scientist-practitioner model, and arguably bringing more emphasis on the self of the CPs to their work. This model and its implications for training will now be discussed.

#### *1.4.1.3 The reflective-scientist practitioner model.*

Perhaps reflecting recognition of the limitations of a pure scientist-practitioner model, the foundations underlying the profession and training of CPs has moved to that of the reflective-scientist practitioner (BPS, 2015). Reflective practice is not a new idea in the training and practice of CPs, however, the move to this model of training has arguably increased its centrality to training and practice. The model is aligned to humanistic and phenomenological approaches to understanding experiences and their impact (Youngson, 2009). It incorporates a focus on the process of clinical practice as well as content and method (Woodward et al., 2015). The model requires CPs to develop self-reflection skills, contemplating their own role in the work undertaken. The focus of the model still emphasises scientific methods, and clinical practice based on knowledge gained from academic theory, research and clinical practice. However, within the reflective-practitioner model these skills are refined via continual processes of reflection. Given the emphasis on reflection within this model, it is important to consider the meaning of reflection and reflective practice, and its methods of development throughout Clinical Psychology training.

#### *1.4.1.4 Reflective practice.*

Within the profession of Clinical Psychology, Personal and Professional Development (PPD) is a key defining elements of practice (BPS, 2006). PPD is defined as a method of developing an understanding of one's own life history and how it may relate to clinical work (Walsh & Scaife, 1998). Both PPD and reflective practice are considered a key ingredient of training and PPD is central to the concept of reflective practice and the reflective-practitioner model (Knight, Sperlinger & Maltby, 2010; Timms, 2007). There are a number of models of reflective practice, much of which is derived from Schön's (1987) seminal work (see Mann, Gordon & MacLeod, 2009, for a review). Lavender (2003) outlines a model of reflective practice relevant to CPs, containing four separate but connected methods of reflective practice:

- **Reflection in action:** the process of reflecting on cognitions and emotions whilst in action. It is often precipitated by an unexpected event, confrontation or when theoretically-based action has reached its limits.
- **Reflection on action:** involving reflecting on action that has already passed.
- **Reflecting on impact on others:** involving an awareness of how one's actions or emotions impact upon others, and are considered key to reflective practice and self-development.



- **Reflecting on self:** involving development of self-awareness and self-understanding.

This model of reflective practice is in line with how other CPs have applied the concept to the profession (Stedmon, Mitchell, Johnstone & Staite, 2003). There is an emphasis on the use of the therapist's own experiences of the work they undertake, considering what is brought to this based on previous life experiences (Stedmon & Dallos, 2009). Arguably, the role of CPs requires working in partnership and in relation to others (Horner, Youngson & Hughes, 2009) and reflective practice requires a consideration of self in relation to others. Reflective practice is a fundamental element of PPD as it encourages consideration of the personal self within professional work: a central tenet of PPD.

As outlined above, the BPS states that PT is not considered an essential part of the training of CPs in the UK due to its historical roots, and because providing therapy is not the primary role of the CP. However, CPs provide many of the therapy services which are available in the NHS (Duncan, 2012; Nel et al., 2012; Wilson et al., 2015). Furthermore, with the shift to the reflective scientist-practitioner model and the growing recognition of the importance of CPs developing as reflective practitioners. It appears critical to have a good understanding of methods for developing these competencies (Binks, Jones & Knight, 2013), of which PT may be one.

A number of methods have been outlined in a review of reflective practice within the profession (Cushway & Gatherer, 2003; Lavender, 2003; Stedmon et al., 2003). One such method is the use of PT, which has been linked to the development of self-awareness, reflective skills, and personal development in a range of studies evaluating the use of PT by psychological practitioners (Nel et al., 2012; Grimmer & Tribe, 2001; Lavender, 2003; Macran & Shapiro, 1998; Rake, 2009; Rizq & Target, 2008a; Rizq & Target, 2008b; Timms, 2010; Wigg, Cushway & Neal, 2011; Wilson et al., 2015). The scope of this review does not allow for consideration of all these methods. Given the literature suggesting that PT is a method for the development of reflective skills and personal development, its relevance to the training of CP's is an important consideration. Research on the prevalence and use of PT for therapists and how it may relate to reflective practice and the reflective practitioner model will now be briefly considered.

### **1.4.2. PT for Therapists**

In order to consider the relevance of PT to the training of CPs, a brief overview of literature pertinent to therapists' use of PT is presented. Research relevant to training CPs will then be presented alongside comparisons.

As outlined above, PT is not a compulsory part of CPs' training in the UK. A variety of other psychotherapeutic trainings emphasise the importance of PT for training therapists (Malikiosi-Loizos 2013). For instance, in the UK, the BPS division of Counselling Psychology requires 40 hours of PT (Rizq & Target, 2008). The United Kingdom Council of Psychotherapy (UKCP) requires trainees to complete PT of the same model, duration, and frequency as that they are practicing (UKCP, 2009b). The British Association for Behavioural and Cognitive Therapy (BABCP) does not currently require trainees to use PT whilst training; however in recent years, research has highlighted the importance of the self-practice of CBT as part of PPD (Gale & Schröder, 2014).

Whilst CPs in the UK are not required to complete PT whilst training, research has indicated that a proportion of the population do. Darongkamas, Burton & Cushway (1994) completed a survey of a random sample of CPs in 25% of 235 NHS district services. The survey had a 65% return rate and analysis demonstrated that 41% of the sample had used PT. A recent study indicated that of a sample of 357 members of the Division of Clinical Psychology of the BPS, 26% had used PT whilst training (Nel et al., 2012). Estimated prevalence rates indicate that a substantial proportion of UK based CPs may access PT, and that potentially a quarter of Trainee CPs may well use PT whilst training.

#### *1.4.2.1 PT for therapists: The rationale*

The rationales for PT as a requirement for training therapists are varied, often being linked to PPD (Rake, 2009). Orlinsky, Boterman & Ronnestad (2001), surveyed 4000 therapists of different orientations and career levels across six English speaking countries. Therapists were asked how much 14 potential factors positively or negatively impacted on professional development. Having PT, analysis or counselling was rated the third most influential, below therapeutic experiences with clients, and formal supervision and consultation. A recent survey of CPs indicated that those who

used PT whilst training considered it as an important or very important aspect of PPD (Nel et al., 2012). Two review papers contribute to understanding and synthesising the available data on therapist use of PT (Macran & Shapiro, 1998; Wigg et al., 2011), these will be briefly reviewed, before presenting a systematic review of the literature relevant to Trainee CPs.

#### *1.4.2.2 Early research on the use of PT by psychological therapists*

A review of literature relating to the use of PT for therapists until 1998 was carried out by Macran and Shapiro (1998). They identified twenty-three studies (predominantly surveys evaluating therapists' views on the experience of having PT) with some naturalistic comparison across therapists who had and had not had therapy. The professional role of the therapists in the studies are varied but most come from Psychiatry, Psychotherapy, Psychology, Counselling, Social Work, or Nursing professions (Macran & Shapiro, 1998). The review provides no details of the search criteria employed, discussion of inclusion criteria for the research evaluated, nor a standardised method for evaluating the quality of the research reviewed. Of the published studies, only three included participants from the UK, many had small sample sizes and much of the research was limited in design due to confounding variables that had not been controlled. Additionally, due to the variety of outcome measures utilised and the focus of research questions, the authors suggest that comparisons across studies are difficult. The limitations of the review, and the quality of the studies reviewed, make drawing generalisable conclusions difficult. The authors conclude that while therapists who have used PT have found it valuable, there is no clear evidence it has made them better therapists in comparisons to non-users. Despite these limitations, the authors synthesised consistent findings across studies and found that:

- Survey data of therapists' PT experiences revealed that most felt PT was personally and professionally useful.
- Most of the studies where therapists were placed in situations designed to replicate clinical scenarios found that therapists who had used PT were more aware of counter-transference situations, and were more active in considering their interactions with clients.
- Across studies there is evidence that PT may have a positive effect on non-specific therapeutic factors often cited as constructive to client outcomes, such as empathy, warmth and genuineness.

- There is some evidence to suggest that PT for trainee or inexperienced therapists is burdensome, potentially having an adverse impact on therapeutic skills.

The authors conclude that more technically sound research is needed in the area, and that process-orientated research may help in understanding the use of PT by therapists. This review was updated by Wigg et al. (2011). The results from this review will now be discussed.

#### *1.4.2.3 Current research of the use of PT by psychological therapists.*

Wigg et al. (2011) provide a systematic review of the literature on therapists' use of PT since 1998. The aim of the review was to critically consider literature relating to the use of PT by psychological therapists, and to draw meaning across the findings, with a particular focus on reflective practice (Wigg et al., 2011). Fourteen studies were identified, of which four were excluded. Only three were with trainee therapists and only one included Trainee CPs. Eight of the studies were qualitative in design, most were surveys, and the rest were process-oriented studies. Similar to the previous review, few studies demonstrated methodologically sound research that therapists who have used PT are more effective than those who have not. Consistent findings across studies indicated that PT was perceived as a positive experience and felt to be beneficial to clinical practice. However, one study identified that PT could increase stress for therapists through difficult issues arising within their own PT (Grimmer & Tribe, 2001). The overall quality of the reviewed research is limited by self-selected recruitment strategies, inadequate measures taken to reduce bias within samples, such as using a control group, small sample sizes, and self-reported measures. The review did however cross-reference and synthesise themes that occurred across the included studies.

Common themes identified across all reviewed studies were grouped into subordinate themes of personal and professional reflection. Personal reflections incorporated the following themes: participants being aware of personal issues impacting on clinical practice, empathetically considering the role of the client, knowing one's own boundaries, and intense self-experiences (Bellows, 2007; Coleman, 2000; Daw & Joseph, 2007; Grimmer & Tribe, 2001; Macran, Stiles & Smith, 1999; Murphy, 2005; Rizq & Target, 2008a; Williams, Coyle & Lyons 1999; Wiseman &

Shefler 2001). Professional reflections incorporated themes of: constructing a professional self via connecting the personal with the professional self; learning models of therapy; greater self-awareness and empathy; and socialisation to the profession (Bellows, 2007; Coleman, 2000; Daw & Joseph, 2007; Grimmer & Tribe, 2001; Macran, et al., 1999; Murphy, 2005; Rizq & Target, 2008a; Williams, et al., 1999; Wiseman & Shefler 2001). Further subordinate themes of extended and meta-reflections were developed, though these only represented data cross-referenced from a handful of studies (Wigg et al., 2011). From the identified themes, a model was proposed in which it is suggested that reflective and reflexive practice is developed within PT via personal and professional reflections. Through these reflections the authors suggest that extended and meta-reflections can be developed. The model is proposed tentatively, acknowledging that further research would need to clarify and substantiate it. It was developed via the cross-referencing of themes across ten studies; the process by which this was completed and the type of analysis that led to model development was not well specified, and therefore the model arguably lacks robustness.

#### *1.4.2.4 Conclusions*

The available literature provides a good understanding of how therapists experience and use PT in their practice. This is however, largely based on subjective accounts (Macran & Shapiro, 1998; Wigg et al., 2011), and there is currently a lack of research demonstrating that therapists' use of PT impacts on clients' outcomes. However, the available data does suggest common experiences in how therapists experience PT and how they perceive these experiences to impact on their practice. The common themes that occur across studies allows for some degree of confidence in potential underlying processes. Therapists' own subjective experiences of PT consistently suggest that it is perceived as beneficial both personally and professionally (Grimmer & Tribe, 2001; Nel et al., 2012; Macran & Shapiro, 1998; Wigg et al., 2011). It has been suggested that this may be related to the process of developing in both personal and professional reflection through experiences in PT, which are subsequently applied in practice (Wigg et al., 2011). Common themes across studies also indicate that PT may provide therapists with the experience of being in a client's position, which seems to allow greater empathy, warmth, and genuineness.

As discussed, models of reflective practice relevant to CPs stress the importance of reflecting on how one may impact on others, which involves an awareness of how one's actions or emotions impact upon others and reflecting on self, which involves development of self-awareness and self-understanding (Lavender, 2003). In synthesising relevant research literature Wigg et al. (2011) suggest that the therapist's personal development within PT relates to them being aware of personal issues that may impact on clinical practice, what it may be like to be in the client's role, knowing one's own boundaries, and intense self-experiences, all of which involve some degree of self-reflection, and reflecting on how one's self may impact on others. Consequently, the literature suggests that therapists may develop in these aspects of reflective practice through experiences in PT. These experiences then seem to relate to practice via the process of constructing a professional self through incorporating the personal into the professional self, which is considered a key aspect of professional development (Horner et al., 2009). Arguably then, the research discussed provides some evidence that through PT's processes, therapists can develop in terms of reflective practice and enhance reflection upon personal and professional issues relevant to practice, a key part of PPD. Therefore, it may be that PT could be a method of developing reflective practice skills in the training of CPs, and that this could support the work of Trainee CPs within the reflective – practitioner model.

Of the three major reviews within the field, none have separated data from trainee therapists, or focussed on the role of PT for the training therapist whilst training. Many of the papers which have included trainee populations (Rizq & Target 2008a, Rizq & Target, 2008b; Williams et al., 1999; Wilson et al., 2015) have asked qualified therapists to look back on their experiences of PT, and are therefore subject to recall bias, and participants may well be removed from the experiences at the time of interview. Given that PT is often mandatory in training, and considered relevant, it is of interest as to whether the experiences of trainee therapists parallel those of qualified therapists. Of particular interest is how experiences may relate to development and practice throughout training. A systematic review of literature pertaining to the role of PT for the training of psychologists will now be presented.

## CHAPTER 2: SYSTEMATIC LITERATURE REVIEW

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### 2.1 Overview

In order to understand the existing literature a systematic review of the peer-reviewed literature was completed. The focus of the review was on Trainee CPs experiences and use of PT whilst training in the UK<sup>2</sup>. Only four relevant papers were identified that met the inclusion criteria (Table 1). The small number of papers identified indicates a paucity of research in the field, and may relate to previous discussions around how PT is valued within the profession (Davidson & Patel, 2009). Research evaluating trainee Counselling Psychologist's experiences and use of PT was therefore included to widen the review<sup>3</sup>, three papers were identified that met the inclusion criteria. The reviewed research of Trainee Counselling Psychologists is presented first, followed by that of Trainee CPs. The data is presented in terms of how it helps in understanding participants' experiences in PT, and how PT relates to Personal and Professional Development (PPD). This will be followed by an evaluation of the presented research<sup>4</sup>. Gaps in the current literature are then identified alongside a rationale for the current study.

### 2.2 Systematic Search

#### 2.2.1 Part one: Initial search

An initial generic search began with a search of relevant websites including the BPS and the Department of Health (DoH). A Google Scholar search was then performed using the terms "Clinical Psychologists" and "PT", 8600 results were yielded, and titles were reviewed for relevance. 40 relevant papers were identified and reviewed for inclusion, of which five were included in the review. Key terms from these relevant papers were used to form the basis of the search terms for the systematic search.

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<sup>2</sup> Consideration was given to including research on trainee CPs from other countries, however given the differences in training, and the potential cultural differences in how PT is perceived, the focus of the review is on UK based studies.

<sup>3</sup> Trainee Counselling Psychologists were considered to be the closest to CPs in terms of training, and potential practice.

<sup>4</sup> See Appendix A for tabulated summary of all reviewed papers and Appendix B for tabulated quality review of all papers outlined in this review.

### 2.2.2 Part two: Systematic search

A systematic search was conducted over an 18-month time frame, ending in April 2017, using SCOPAS, PubMed, and EBSCO. No parameters were set for search time period. Terms used include PT, Therapy, Clinical Psychologists, Trainee, Trainee Clinical Psychologists, Psychologists in Training, and Counselling Psychologists.<sup>5</sup> Additional searches were performed, including the terms Reflective Practice, Personal and Professional development. No further included papers were sourced from adding these terms. Relevant articles were identified through a review of either abstracts or full texts<sup>6</sup> and were included or excluded based on the criteria outlined below. References of relevant articles were scrutinised to identify articles that had been missed during the search.

Table 1: Systematic Review: Inclusion and Exclusion Criteria

<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Peer reviewed	Non-peer reviewed
Literature relevant to current research	Literature not relevant to the current research
Available in English	Not available in English
UK-based trainee CPs included	No UK based participants in the study
Clear that participants include CPs or Counselling Psychologists trainees, and data from this group of participants can be distinguished from alternative professional groups.	Unclear if participants were CPs or Counselling Psychologists trainees, or difficult to distinguish data between these and other professional groups.

### 2.3 Overview of Literature: PT for Counselling Psychologists

Three papers met the inclusion criteria and are reviewed in terms of what they tell us about Counselling Psychologist's training experiences of PT and its relation to PPD and reflective practice.

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<sup>5</sup> See Appendix C: Part A for full details of search strategy and parameters.

<sup>6</sup> See Appendix C Part B for details of sources by which papers were identified.



### **2.3.1 Experiences in PT**

Of the three papers exploring Counselling Psychologists' experiences of PT, all considered the role of mandatory PT. Williams et al.'s (1999) retrospective survey of Counselling Psychologists found that the majority of participants (88%) felt PT should be a mandatory component of training. Of these, 66% felt this way despite reporting some negative effects of PT whilst training. Results indicated that participants valued experiences in PT, and would perhaps have used PT whether obligatory or not.

The qualitative research reviewed supported the idea that Counselling Psychologists understand mandatory PT to be an important part of training (Grimmer & Tribe, 2001; Kumari, 2011). In research carried out by Kumari (2011), seven Trainee Counselling Psychologists in the second and third year of their training were interviewed about their mandatory PT experiences, and how it related to their PPD. Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) was used to examine the data. A superordinate theme constructed from the data was 'Changed Attitudes Towards Compulsory Therapy'. Participants described moving through a process of coming to believe that obligatory therapy was important to training through experiences in PT. Respondents talked about initial feelings of anger and frustration at feeling forced into therapy. Most participants talked about how the inclusion of 40 hours of mandatory PT within a certain time frame felt highly pressurised, and many believed that the way mandatory PT is administered within training needed adapting. One participant discussed the need for more choice regarding when PT is used, another suggested that more information from the course about the benefits of PT during training may have helped in understanding mandatory requirements.

Grimmer & Tribe (2001) investigated Counselling Psychologists' opinions on the experience of mandatory PT in relation to PPD. Participants were either Trainees or recently qualified. Seven participants took part in a group interview explicitly discussing the inclusion of mandatory PT, and seven participants took part in in-depth individual interviews related to PT experiences. Grounded Theory (GT) was used to analyse data. Core categories constructed from the data did not include processes related to the mandatory inclusion of PT. It is however suggested that the fact that therapy is mandatory does not seem to limit the range of outcomes available to

participants. This may, however, reflect the author's opinions, rather than those of the participants, which are not detailed.

The data across studies seems to suggest that participants viewed their experiences of PT as being important to training, particularly in relation to PPD (Grimmer & Tribe, 2001; Kumari, 2011; Williams et al., 1999), and most report positive outcomes (Williams et al., 1999). However, many participants reported negative aspects of PT whilst training. In Kumari's (2011) study, a superordinate theme constructed from the data was "The stress of therapy", and included sub themes indicating the cost of PT, the pressure of restrictive time-frames, the scheduling of PT, and the fact that therapy can disrupt clinical work were all seen to be negative aspects of the experience. In Williams et al's (1999) study, six per cent of participants reported negative outcomes of PT. So whilst studies indicate some degree of commonality in participants describing positive experiences from PT during training, it is important to consider that using PT whilst training can also have a negative impact, and that negative experiences are often related to mandatory PT. Given the perceived importance of PT to PPD across studies, the review will now discuss findings relating to this.

### **2.3.2 The role of PT in personal and professional development**

Williams et al. (1999) provide some understanding of the impact that PT may have on participants' practice. Participants used a five point Likert scale to rate the extent PT impacted on certain elements of professional practice. Elements of professional practice were constructed by the authors based on prior research. These can be delineated into factors related to the therapeutic alliance, ethical issues, theory-practice links, personal development, professional issues, and understanding clients. A principal component factor analysis was used on participants' ratings in order to try and determine broad underlying processes of practice related to experiences in PT. Three factors with simple structures explained 72% of the variance in the model. Factor one was professional issues and included items learning about therapy, learning about the therapeutic process, and the therapeutic alliance and relationship. This factor explained the largest proportion of the variance (52%). The second factor related to problems arising in training to be a Counselling Psychologist and explained 10% of the variance. Finally, factor three related to personal issues and explained 7% of the variance. It seems that professional learning, as well as support with

training and personal issues, is an outcome of PT for these participants, and that PT may have assisted in helping them to learn about therapy, and the therapeutic process. This is also supported by the qualitative studies.

In the research conducted by Kumari (2011), four superordinate themes were constructed from the data. Two of these, 'experiential learning' and 'personal development', related directly to PPD. Experiential learning was considered a valuable opportunity to gain specific skills and to try to use these in clinical work. These included: skills in understanding and developing therapeutic relationships, learning first-hand about techniques, and knowing what it feels like to be the client. A second theme of 'Personal Development' suggested that participants saw PT as the first stage in a lifelong journey of personal development. Subthemes included: ways in which PT was important to personal issues, having a deeper understanding of self; relevant to practice, and developing insight and self-awareness; important to practice. These results indicate that participants developed through PT experiences both personally and professional. The development of self-awareness seems to be a particularly relevant aspect of personal development related to practice. Experiential learning seems to give participants a personal experience of being in the role of the client, which served to impact on professional practice via improving understanding of the process and content of therapy.

Grimmer and Tribe (2001) identified four overarching categories in analysing data from 14 participants' accounts of experiences of PT whilst training. The processes constructed from the analysis of data reflect important aspects of how PT impacts upon PPD. The first category was: Reflection on Being in the Role of the Client; through this process participants described better understanding the therapy process for clients by reflecting on their own therapeutic experiences. They were likely to replicate positive experiences and avoid replicating negative experiences. Similarly to Kumari's (2011) findings, this process seems to describe participants developing through experiential learning that is then applied in practice. The second category was named Socialisation Experiences, and describes a process of participants seeing PT as a rite of passage in their professional role. This seems to occur via experiences in PT that support the emerging professional, and include modelling their own therapist in practice, and having an experience of either a model of therapy, or a process in therapy being validated through personal experiences.

Socialisation experiences seemed important to developing a sense of professional identity via having aspects of the professional role validated within PT. Interestingly the final category is labelled, Interactions Between the Personal and Professional. This process described participants' development of self-awareness which was understood as impacting on their understanding of relationships with clients.

The reviewed studies provide some support for PT being viewed as a method for helping Trainee Counselling Psychologists to develop both personally and professionally through their experiences of being in PT, with important processes seemingly absorbed through being in the role of the client, and developing self-awareness that is subsequently used to aid professional practice. The research does however have some limitations which will now be considered.

### **2.3.3 Critical review**

To assess the quality of both the qualitative and quantitative research within the systematic review, guidelines set out by Elliot, Fischer and Rennie (1999) were utilised. Whilst the title of this paper is specifically related to qualitative research, quality guidelines are provided for quantitative and qualitative research<sup>7</sup>.

Both qualitative studies provide an account of the researchers' relationship to the research, and provide transparency around interest and experiences related to the topic. Both contribute to understanding how Counselling Psychologists use PT and how it may relate to PPD, supporting its inclusion in training. Given that the Grimmer & Tribe (2001) paper is a GT study it is limited by the fact that there is no model of the processes described, or how categories may relate to one another. There are limited extracts of the data, making it difficult to ascertain the extent to which the theory is grounded in the data. Kumari (2011) provides extracts from the data which illustrate the themes derived, and an understanding of the process of analysis.

Limited credibility checks are described in both studies, impacting on the rigour of the findings. Both studies have a general aim of expanding understanding of how a group of participants experienced PT whilst training. They are explicit in stating that these results are not necessarily

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<sup>7</sup> See Appendix B for a tabulated review of how the systematic review papers meet the quality criteria outlined by Elliot et al, 1999.

transferable to others within the population, and that further research would need to clarify underlying processes identified. A strength of both papers is that the themes and categories that were derived from the analysis have a significant overlap, and therefore resonate with one another (and the wider literature), which suggests PT as a method for PPD for therapists.

The quantitative study aimed to gather general information to address how Counselling Psychologists viewed mandatory PT and how it related to practice. The use of a survey was appropriate in gathering this information. Conversely, the survey is ambitious in its aims of understanding the process of PT, its outcome, and how it is used in practice within a survey design. The use of closed-ended questions addressing complex experiences is questionable. Equally, responses to process, outcome, and how this related to professional practice is based on categories pre-designed by the authors, and may not capture subjective experiences. Some participants commented that the questions were irrelevant to their own experiences. The study is considered useful in understanding participants' views on mandatory PT and its positivity or negativity within the context of the sample. However, the results are not considered to be generalisable to wider Counselling Psychology populations; consequently, results on processes and outcomes of PT and its relation to practice should be viewed cautiously.

A critique of all of the reviewed papers is in the self-selection methods of recruitment used which impact on the generalisability and credibility of the results. However, results across studies do resonate with the literature on therapist usage of PT, and the commonalities suggest that there can be some degree of confidence in the findings. It may however be that results are better understood in terms of participants who have had meaningful experiences of PT. Nevertheless, for a proportion of the Counselling Psychology population, PT presents as a relevant aspect of PPD and an important element of professional practice.

#### **2.3.4 Conclusions**

Despite limitations with the reviewed research it seems that for a proportion of Counselling Psychology Trainees that PT is an important aspect of PPD, and that experiences of personal development may serve to impact on professional development via developing self-awareness, and having an experience of being a client. The development of self-awareness related to practice could

also be considered as a development in reflective practice (Lavender, 2003) and therefore experiences in PT may serve to develop reflective capabilities that are relevant to professional practice. It seems that the mandatory element of PT for Counselling Psychologist may negatively impact on how it is experienced. However, it does seem that for some the experience of PT seems to mitigate the negative impact it could have. There are distinct differences in the training of Counselling and CPs, and PT is not mandatory in CPs' training. So whilst the reviewed research suggests that PT appears a method for Counselling Psychologist to develop both personally and professionally, in what are described by many as extremely meaningful ways, it would be useful to understand if PT would be useful to CPs in the same way. The review will now turn to understating the relevant literature on CPs use of PT.

## **2.4 Overview of Literature: PT for Trainee CPs**

Four studies relevant to CPs' experiences of PT were included in the study. It is interesting to note that studies are sparse within this population. Two papers have been included in the review where the research questions are not directly related to experiences in PT (Nel et al., 2011; Digiuni, Jones & Camic, 2013). The limited research in this area may reflect the fact that PT is a non-mandatory element of training, or may relate to earlier discussions around avoidance of the topic within the profession (Davidson & Patel 2009). Given that a number of training courses promote or provide information on PT (Timms, 2010), evidence suggesting trainees may experience distress during training (Cushway, 1992), and ideas related to some CPs being wounded healers (Aina, 2015), having an understanding of trainees' experiences of PT and how these may relate to practice is perceived as important to the profession.

### **2.4.1 Experiences of PT**

As discussed, PT is a non-mandatory aspect of training CPs. Consequently, there is interest in what may impact on people's decision to use PT. Digiuni et al. (2008) completed a cross-national study which examined the relationship between trainee CP's perception of social stigmas attached to receiving therapy and their attitudes toward seeking therapy. Trainee CPs completed a survey, of which 211 were from England, 130 from the US and 121 from Argentina. Standardised measures,

with adequate psychometric properties, were used to measure perceived social attitudes towards seeking PT<sup>8</sup>.

Hierarchical multiple regression (HMR) was used to establish whether perceived social stigma would predict attitudes towards seeking therapy, when controlling for courses' views of PT, and prior experiences of PT. Within this model, with data from all three countries collated, perceived social stigma for seeking therapy was a significant predictor of attitudes towards seeking therapy. Data from each national group was then imputed separately using the same model. For the English group, how course faculties viewed therapy was the most reliable predictor of attitudes towards seeking therapy, with social stigma also being a significant predictor.

Results suggested that for the English sample, appraisals as to the benefits of seeking therapy may be impacted by how participants perceived others (faculty members and wider society) to view this. This implies that the way in which training courses present information on the use of therapy whilst training may impact upon how it is perceived and taken up, as well as the perceived wider societal discourses around using therapy. Professional discourses around the use of PT could then be important in trainee's attitudes to seeking PT. The authors suggest that it seems important that training courses encourage trainees to take an open and curious position in relation to PT, suggesting this could be achieved by exploring research in relation to therapists' use of PT and its impact on professional and clinical practice. Research relating to trainees' use of PT and its impact on practice would therefore be a potentially valuable contribution to such discussions. The reviewed qualitative research supports the idea that stigma, particularly within the professional context, may impact on trainees' experiences of PT.

Wilson et al. (2015) completed a Narrative Analysis of ten female participants' experiences of accessing PT during training. Participants took part in an individual interview, being asked to share stories of accessing PT whilst training. The authors present three 'chapters' describing shared narratives across participants. One of these chapters is 'The stigma of therapy – "Oh my god it's so shameful"'. It seems there were shared conversations amongst participants around the stigma of

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<sup>8</sup> See Appendix A for details of measures

accessing PT. One participant talks of feeling that there is an assumption within the profession that CPs should not need their own PT:

*...we're clinical Psychologist, we're the experts, we don't need therapy. (p. 38)*

Others discussed that it may be perceived as a weakness to access PT, particularly by the training course staff, and certain participants felt inadequate for accessing therapy, in comparison to their peers:

*...makes you think there's something wrong with saying you're going for therapy. (p. 38)*

These results are important in thinking about how trainee CPs may experience PT, as well as what may inhibit trainees from accessing PT. Participants' experiences certainly seem to have been impacted by a perceived rhetoric within the profession that in order to practice clinically CPs should be immune to psychological difficulties.

It could be that stigma prevents trainee CPs from accessing PT. For those who do use PT, stigma may impact on how they feel about themselves for making this decision. Interestingly, stigma related to accessing PT does not seem prevalent in the reviewed research on Trainee Counselling Psychologists this may be because, within this context, the mandatory nature of completing PT implies its professional significance. The results of the Narrative Analysis do however need to be viewed with scepticism, due to the quality of both the design and analysis<sup>9</sup>. Results from a further study of CPs' experiences of PT (Moller, Timms, Alilovic, 2009) do not indicate stigma impacting upon experiences. It is worth noting however that in this study participants received funded PT, and this may have impacted on how they perceived their course to value PT.

In Moller et al.'s (2009) study, eleven Trainee CPs, 13 Professional Doctoral students in Counselling Psychology, and 13 Counselling Diploma Trainees completed open-ended questionnaires investigating the relationship between PT and training, whether it should be compulsory, rationales and difficulties with engaging with PT, and potential scope of therapy. Data was analysed using Thematic Analysis. The data was analysed across the differing groups, which is problematic as CPs were the only group not-obligated to complete minimum numbers of PT hours. However, the authors suggest that they were surprised by experiential commonalities across

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<sup>9</sup> See appendix B for further details on quality



groups, giving examples within their results of data extracts from each of the different groups supporting themes constructed from the data<sup>10</sup>.

Two main themes were derived from the data: PT helps me to be a better practitioner, and PT “costs me”. In terms of benefits, trainees reported that PT could be a space that was protective whilst undertaking an arduous course. PT was viewed as providing a ‘safety net’ which enabled participants to work through things that may be affecting them. Data derived from the Wilson et al. (2015) research also suggested that PT could be a method for coping with training-related stressors. Chapter one of the analysis was ‘Being a trainee – “You can take all your stresses to therapy”’. Many participants described how stressors within training often acted as a catalyst for using PT, and that PT provided support through the stressors of training. Across the two qualitative studies described, it seems that participants have used PT as a supportive space to cope with some of the stressors of training. Participants do however, speak of negative aspects of PT whilst training.

In Moller et al.’s (2009) study, a constructed theme was ‘therapy costs me’. Which referred to financial impingements, the opening of psychological wounds, and negative impacts on training related study. Financial costs were not as relevant for the Trainee CPs as their PT was partially funded by their training programme (up to ten sessions). The subtheme ‘opening a can of worms’ was talked about in relation to participants’ descriptions of the difficulties dealing with issues emanating from PT. This was mirrored in Wilson et al.’s (2015) study, with some participants describing difficult emotions throughout their PT journey, leaving potential feelings of vulnerability, and intermittent feelings of negativity towards therapists. Many participants also suggested that PT did sometimes interfere with training by leaving them feeling raw. The results of both qualitative studies describe how training can lead to stress or vulnerability, which may be dealt with through using PT. However, it seems that PT can also sometimes cause distress which can impact upon training, presenting something of a double bind. Despite the potential for PT to have a negative impact on training at certain points, the reviewed research suggests that it is still considered relevant to PPD, which will now be discussed.

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<sup>10</sup> All extracts used within this review reflect data from CPs

### **2.4.2 The role of PT in PPD**

In a study by Nel et al. (2012) a sample of 357 qualified Psychologist completed a retrospective survey investigating the perceived value and usefulness of learning activities used during training. Of these methods, PPD and PT are considered as potential learning activities/methods to support this. The survey assessed firstly if participants had been exposed to certain learning activities, using a dichotomous scale indicating exposed or non-exposed. The second part of the survey assessed how participants rated and ranked the learning methods of activities they had been exposed to. A Likert scale was used with a range of 1-5, with 1 indicating that the method was of no importance and 5 that it was very important. Finally, open-ended questions assessed if participants felt that any method or learning activity that had been useful had not been included in the survey, and if they had any further comments to make.

Descriptive results indicated that 26% of the sample had used PT whilst training, 88% of those participants considered it to be an important or very important learning method as part of their PPD. Open-ended questions were analysed using thematic content analysis. Five themes were identified, one of which was 'The importance of PT for learning'. The authors comment that most, if not all, of the participants who had used PT commented on the fact that PT was not part of their training and that this was regrettable. Results of this study indicate that for users of PT, it was considered an important part of their PPD. This is supported by qualitative data.

Moller et al. (2009) found that one of the benefits of PT described by participants was 'PT helps me to be a better practitioner'. Results suggested that this may occur via experiential learning which is then applied in practice. In addition, the trainee CPs group in this study identified that interventions and models could be learned about through experiencing them in PT. In Wilson et al.'s (2015) study, all participants noted how PT had impacted on their professional identity and clinical practice, and one way that this process seemed to occur was via experiencing being in the client role. The importance of being in the role of the client as an experiential learning method was also noted in the Counselling Psychologists research reviewed, as well as in the wider literature on therapists' use of PT (Wigg et al., 2011).

Personal growth and development were also found to be important aspects of PT for trainees in both studies. Much like the reviewed research on Trainee Counselling Psychologists, in the Moller et al. (2009) research, trainees linked this to having increased self-awareness, and working through personal issues. Within Wilson et al.'s (2015) study, participants talked of seeking more supportive friendships, taking responsibility for their own feelings, as well as improved self-relationship, all relating to personal development. In the Moller et al. (2009) study, participants made links between improvements in their own psychological functioning/personal development during PT which was perceived to result in being able to work more safely with clients.

Taken together it can be seen, primarily through experiential learning experiences and personal development and growth which may be applicable to professional practice, that the reviewed studies suggest that PT may support Trainee CPs' PPD. Both of the qualitative studies do however have methodological limitations; a critical review of the reviewed research will now be presented.

### **2.4.3 Critical review**

Research by Digiuni et al. (2008) provided useful contributions to the research literature as the first study to consider the role that perceived social stigma may have on trainee's attitudes to PT. On the whole the quality of this research was sound, meeting quality criteria<sup>11</sup>. It is however worth noting that due to the cross-sectional nature of the design, causality is undeterminable. Results can then only explain that there is an association between perceived social stigma and attitudes towards PT. Although certain confounding variables were controlled, based on the reviewed literature there may well be other confounding variables that could impact on attitudes towards PT, mainly perceived costs (financially, emotionally and practically) that were not considered. The study contributes to an understanding that social stigma may impact on attitudes towards PT, however it is unclear if this would impact on the behaviour of taking up PT whilst training.

Nel et al.'s (2012) survey contributed to an understanding of learning activities during CPs' training that were perceived to be of importance. Given that the study asked participants to rate whether they had or hadn't experienced PT whilst training, the study also contributes to providing an estimate of the percentage of trainees who may use PT as part of training, and how important

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<sup>11</sup> See Appendix B for further details of quality of reviewed research

they considered it to their learning in PPD. This is the first UK based study that has considered this and thus aids in understanding the role of PT in the training of CPs in the UK. The main limitation of the study is that participants were self-selecting and were varied in terms of duration of years post-qualification. Many of the participants had been qualified for two-decades and, as such, retrospective accounts of learning whilst training may be flawed.

Both of the qualitative papers reviewed have several limitations. Moller et al.'s (2009) study looked at data across three different professional groups, with difficulty in determining the relative contribution of each group to the development of themes. The authors were all involved in the teaching of the participants who took part, the dual role may well have impacted on the participants who choose to take part in study, as well as responses, potentially impacting on respondent and self-selection biases. The CPs in the study were provided with ten free counselling sessions. There is little information on the type of counselling, how this was arranged, or how decisions were made about whether to use this facility, which undermines understanding of these processes. It could also be argued that having funded PT, versus self-funded, may well impact on the considered value of it. It is worth noting that participants were interviewed in their first three months of training, therefore experiences described may only help in understanding the early stages of PT. Studies with Counselling Psychologists have indicated that PT may be detrimental in these early stages of training (Grimmer & Tribe, 2001), and so this may subsequently have impacted on the experiences of participants within this study, consequently affecting the results. Given the limitations of this study, the results should be viewed with caution, and the theoretical understanding of trainees' experiences may not be translatable to the wider population of Trainee CPs.

The research by Wilson et al. (2015) had the potential to offer a valuable contribution to understanding how participants have experienced PT whilst training, however, the methodological limitations impact on the integrity of the data. Whilst the author acknowledges that she is a Trainee CP, she does not offer an understanding of her views or experiences of PT whilst training or how this may have impacted on research processes. The sample was limited, including only women, and some of the participants were funded by the course for PT; it is also unclear if all participants shared the same course or geographical location. Although there is some description of the analysis procedure, it is not detailed enough to understand the process, and there is no reference to the type

of narrative analysis which was used, how this was decided upon, or how this fits with the overall framework of the study. Understanding the links between the data, findings and interpretations is therefore difficult. Qualified CPs were being asked to reflect back on their experiences of PT whilst training and offering retrospective accounts. This may impact on the meaning that participants make of their experiences when compared to trainees who are in the process of PT whilst in training.

The quantitative studies reviewed are helpful in providing information related to trainee CPs' use of PT whilst training. The limitations of the qualitative studies make it difficult to interpret findings and consider how these may relate to training CPs. Overlapping themes in both studies related to the importance of experiential learning via being in the role of the client, and in aspects of personal development suggesting that these may well be relevant processes that occur through the use of PT. These processes were also identified in the discussed research related to training Counselling Psychologists, and may therefore lend some credibility to the notion that these processes are important aspects in trainees' experiences of PT.

#### **2.4.4 Conclusions**

There is a limited amount of research into Trainee CPs' experiences of PT whilst training and how these may relate to training and practice. Perceived stigma has been identified as impacting on trainees' attitudes to PT, and it may be that this impacts on decisions to use PT. Given that the described research has indicated that training is conceptualised by many as stressful and potentially distressing, the fact that stigma may act as a barrier to accessing PT is something that needs further consideration. For those who do use PT, results have indicated that stigma may impact on experiences for some, and elicit feelings of weakness, or questioning of fitness to practice. It may be that how courses and the wider profession consider the role of PT is important, as well as having open conversations about training, and the role of PT within this. Further research understanding participants' experiences of PT and how it relates to their training would potentially be useful to trainees and trainers in facilitating these conversations.

Survey data suggests that PT is viewed as an important part of PPD for those who used it whilst training (Nel et al., 2012). The qualitative studies addressing how PT may relate to PPD are

methodologically weak and therefore limit what can be understood and applied. Some data derived from these does however resonate with the literature on Counselling Psychologist's experiences of PT. Processes relating to trainees developing in experiential learning via being in the client's role, and in personal development related to practice are found across studies. These processes may then reflect ways in which Trainee CPs can develop in PPD through experiences in PT. Given that personal-learning, and well developed self-awareness, are key parts of the reflective-scientist practitioner model of training, it may be that PT could be considered a method for helping trainees to develop in reflective practice relevant to this model. The data reviewed suggests that experiential learning and personal development are important aspects of experiences in PT for Trainee CPs, however there is not an understanding of the processes by which these are developed, or a good understanding of how they may relate to practice.

## **2.5 Clinical Relevance and Rationale**

There is limited research that has been conducted into Trainee CPs experiences of PT during training. None has addressed the process or mechanisms by which PT may be utilised and related to development within training. The available research points to the need for further clarification and guidance on the use of PT for Trainee CPs. This study will further the understanding of the processes by which PT is experienced and how it relates to Trainee CP's development through training. It is hoped that the results will help to inform the development of clearer guidelines on the utility of PT throughout training. The research will add to the literature on PT as a potential training method, particularly relevant with the move to the reflective-scientist practitioner model of training.

In light of the above, the aim of the project is to develop a preliminary, yet substantive, understanding of the mechanisms through which Trainee CPs experience PT and how it relates to development within training. The main research question is:

*How do Trainee CPs experience their own PT and how do experiences relate to development in training?*

### 3.1 Overview

In this chapter, I will provide details of the research methodology used to address the research question, and the rationale for using such methods. The discussion will then move to an explanation of how my epistemological position relates to the methodology, providing a justification for the use of GT. Details of the research design, coupled with information regarding how participant's experiences were elicited, are then discussed. Subsequently, the process of data analysis is provided. The chapter is concluded with an explanation of the measures taken to meet quality criteria for qualitative methodology. This information should allow the reader to evaluate the credibility of the research<sup>12</sup>.

### 3.2 Methodology

#### 3.2.1 Qualitative Research

Within the field of psychology there are debates around the appropriateness of using quantitative or qualitative methods (Biggerstaff, 2012). Quantitative methods are typically concerned with establishing cause and effect and testing theory based on controlled variables in order to establish the predictive generalisability of a theory's 'truth' (Creswell, 2012). These designs are limited when investigating experiences and meanings that cannot be objectively measured and evaluated (Biggerstaff, 2012). Qualitative methods, however, offer a way of evaluating subjective experiences or processes that do not typically lend themselves to quantitative enquiry, and are typically considered to be more appropriate when exploring people's experiences (Creswell, 2012).

As discussed, given the paucity of research evaluating the use of PT for trainee CPs there are no existing hypotheses or theories available to test. There is, however, a need for exploratory research to understand meaning, experiences, and processes. This research therefore lends itself to qualitative enquiry. Given that there are numerous qualitative methodologies, the discussion will

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<sup>12</sup> For ease of reading personal reflections are presented in italics throughout this chapter

now turn to a consideration of the research questions and epistemological position of the study in order to select the most appropriate methodology.

### **3.2.2 My epistemological position**

Discussion of my epistemological position and personal journey to the research is outlined in the Introduction. It is my understanding that research always reflects value positions; consequently I have outlined my personal ideas encompassing the value I have found in using PT whilst training. I continue to discuss how I have tried to keep myself open to other stories that my participants have to tell. I return to my epistemological position within this chapter to discuss how this has impacted upon the research design and approach to data analysis.

As postulated, this research is conducted within a social constructionist frame. Constructionism holds that there is no single objective truth and that it is the social interactions between people that create versions of knowledge (Burr, 2003). As discussed previously, there is limited understanding of how trainee CPs may experience PT whilst training, and how it may relate to or support them within the context of their development in training. The current research question seeks to address this, by considering '*How trainee CPs experience their own PT and how these experiences relate to development in training*'. Understanding this requires comprehending the wider context and dominant discourses around the use of PT within Clinical Psychology in the UK, which has been outlined. This research places value on the unique experiences of individuals and considers contextual factors potentially impacting on the stories being told. A constructionist position has therefore been adopted. Consequently, my role in the construction of the research question, how I gathered data and interacted with participants, as well as the ideas that I have brought to analysing the data is made explicit throughout. Social constructionism forms the basis of all aspects of the research design and method. In line with this epistemological position, as well as the need to conduct research that may illuminate the processes involved in participant's experiences of PT, constructionist-grounded theory was selected to address the research question.

### **3.2.3 The case for grounded theory (GT)**

GT is a qualitative method for both gathering and analysing data, with the aim of constructing a middle-range theory grounded in the data (Glaser & Strauss, 1967; Charmaz, 2008). It begins with



inductive methods for collecting and analysing data, which is then constructed into a theoretical model used to assist in explaining the phenomena being studied (Charmaz, 2008). There are a number of strategies used within this method to focus data-gathering and analysis. However, the method is arguably developed and utilised differently, depending on the research setting, the researcher, and the data itself (Charmaz, 2008). Specific methods used within this GT study will be outlined.

Unlike other types of qualitative enquiry, GT is suggested to answer ‘why’ questions as well as ‘what’ and ‘how’ questions (Charmaz, 2008). It is for this reason the method was selected for the current research. As discussed, there is some research examining CPs’ experiences of PT whilst training (Moller et al, 2009; Wilson et al, 2015) but this research does not evaluate processes related to how participants experience PT. There is also evidence that PT during CPs’ training may impact on PPD, though it is not clear why or how this may happen. For these reasons GT was selected as a method of enquiry that could address these ‘what’, ‘why’ and ‘how’ questions and to begin developing an explanatory model. Given that the end product of GT is a tentative explanatory framework of the processes under investigation, it was considered the most clinically useful method for informing training courses and trainees, of the potential processes involved in using PT whilst training.

GT methodology has evolved as a qualitative methodology, and can be used in both an objectivist or constructionist format, depending on how it is conducted (Charmaz, 2008). The objectivist form of GT assumes that data is self-evident and that theory emerges from the data. The purpose of the method is to generalise through abstractions, separating the completed GT model from the context and conditions of the data collection and analysis (Charmaz, 2008). In contrast, constructionist GT makes the assumption that researchers construct categories of the data, and aims to use participants’ views and voices as an integral part of analysis and its presentation (Charmaz, 2008). For the purpose of this study, the constructionist GT has been utilised (Charmaz, 2008).

### **3.2.4 The choice of GT over other qualitative methods**

Consideration was given to phenomenological approaches, and particularly Interpretative Phenomenological Analysis (IPA). The goal of phenomenological approaches is to explore how

participants make meaning of their lived experiences, through the researcher making explicit underlying assumptions in the person's explanation of their experiences (Starks & Brown Trinidad, 2007; Willig, 2013). In relation to the research questions, this methodology could have been useful in considering participants' experiences within PT in a rich and detailed manner. It would not, however, have been useful in developing a theory of understanding, or in thinking about the relationship between experiences and development.

Discursive methods, such as Narrative Analysis (NA) may have been useful in illuminating how participants narrate their experiences over time, and how these relate to the social discourses available to them to discuss experiences of PT (Riessman, 2008). The temporal aspects of NA may have been useful in considering participants experiences over the course of PT, and perhaps training. However, given that prior research has used this method within a similar population (Wilson et al, 2015), and given the research question is focused on understanding the processes by which experience and development may happen, this methods would not have adequately answered the research question.

Ultimately, it was thought that GT was the most likely method to produce clinically useful results for trainee CPs, training courses and the wider research community compared to other methods. Understanding how people may use PT during training, how it may impact on development, and a consideration of why this may be was considered to be the most helpful. This was discussed in a series of consultations which will be explained when the design of the project is described.

### **3.3 Design**

#### **3.3.1 Consultation**

The study was developed and completed over two years. In determining if this research may be useful, the development of ideas was discussed with trainee CPs, qualified CPs, and with the research team involved with the project. From the outset I met with all these individuals to discuss ideas, topics, and the wording of the information sheet, as well as interview schedules. I also attended a series of workshops on GT, which allowed for consideration of methodological research design.

One of the trainee CPs with whom I was consulting agreed to a practice interview. This was particularly helpful in thinking through elements of the interview schedule. It provided the opportunity to think with her about what it was like to answer the questions, and whether there were questions or ideas missing from the schedule that would help participants in describing their experience of PT.

### **3.3.2 Sampling strategy**

In the early stages of research, participants were selected using a purposive sampling approach to ensure that they met the criteria of the study. Given the method, it was desirable to recruit a heterogeneous sample of trainee CPs in order to understand experiences across a broad demographic. Given this, attention was paid to recruiting participants at different stages of training, who had begun using PT at differing times during their training, from a broad geographical area. Attempts were made to recruit participants who had used a range of theoretical models of PT, this however proved difficult, as all who came forward has used some form of psychodynamic PT. It is important to note that sampling was also opportunistic; many participants replied to initial recruitment strategies, and although participants were recruited from across wide geographical locations, convenience and time also played a role in participant recruitment.

Given the amount of data provided at interview, the value of exploring the data in depth, and the time and resource limitations of the study, it was anticipated that a sample of ten to twelve participants would be appropriate. Part of the method of GT involves the concept of theoretical sampling, in which the number and type of participants recruited are partially determined by the emerging theory. As far as possible sampling was completed within this framework. For example, as the emerging theory served to demonstrate that the way in which courses supported the use of PT could impact on experiences, participants were recruited from courses where PT was and was not encouraged.

Within GT, sampling should be continued until the theoretical saturation is completed. It was felt that partial saturation of core conceptual categories was met after ten interviews. A further three participants were recruited to provide feedback on the validity of the emergent model.

As this research aimed to explore trainee CPs' experiences of PT whilst training, and as related to development in training, the following inclusion criteria was used:

1. Currently in CP training at a UK based course;
2. Completed four or more sessions of PT whilst training.

### **3.4 Ethical Considerations**

#### **3.4.1 Process of ethical approval**

Full ethical approval was sought from the University of Hertfordshire's Health and Human Sciences Ethics Committee, (registration no: LMS/PGR/UH/02421: 16/06/2016)<sup>13</sup>. Further ethical approval was sought to use transcription services<sup>14</sup> Transcribers signed confidentiality agreements for the work they undertook<sup>15</sup>.

#### **3.4.2 Explaining the research**

Given my dual role as researcher and trainee, I felt it was important to be explicit about how I had become interested in the project, and the aims and purpose of my research. Individuals who expressed an interest in taking part were given an Information Sheet containing the aims of the research, what would be required of them and, information on how to withdraw<sup>16</sup>. Participants were asked if they would like to ask any questions about the research and were provided with mine and my supervisor's contact details. At the beginning of each interview I talked through the information sheet again with participants, offering opportunities for questions, and the opportunity to withdraw. I also informed participants that they were not obliged to answer any questions that they didn't want to answer.

#### **3.4.3 Confidentiality and Consent**

The information given to participants allowed them to make informed decisions about whether they wished to partake in the study. Prior to completing the interview, participants were asked to read and sign the consent form and were asked if they had any questions about any part of the

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<sup>13</sup> See Appendix D for a copy of evidence of ethical approval

<sup>14</sup> See Appendix E for a copy of evidence of ethical approval for transcription services

<sup>15</sup> See Appendix F for a copy of signed confidentiality agreement from transcription services

<sup>16</sup> See Appendix G for a copy of participant Information Sheet

process<sup>17</sup>. It was explained that the interviews would be recorded and that either myself or a professional transcription service would transcribe the interviews<sup>18</sup>. All participants were happy to sign the consent form, and none have opted to withdraw their data. It was also explained, that within the write up of any results, anonymity and confidentiality would be ensured by removing any identifying information, anonymising quotes, and using aliases. Identifying details of training courses attended was also removed. All interview data was stored as password-protected files on my password-protected laptop. Hard copies of data were stored in a locked filing case, accessible to me only. Identifying information about participants, such as consent forms, was kept separately from data. Data was stored under numeric codes which only I could trace back to individual participants.

#### **3.4.4 Potential distress**

Participants were invited to talk about their experiences of PT whilst training. For some participants having a space to think about this may have been helpful (Birch & Miller, 2000), whilst for others I was aware that this may be upsetting. Participants were reminded at the start of the interview that it could be stopped at any point. To conclude the interview, participants were asked what it had been like to take part, and to discuss any questions or concerns that they had. One participant did find talking about her decision to use PT quite challenging, and this participant was given the option to stop the interview, to take a break, or to carry on with the interview. We took two breaks throughout, but this participant wanted to complete the interview and felt it was important for people to have an understanding of how she was experiencing PT whilst training.

#### **4.4.5 Safety Precautions**

Given that interviews were taking place in participants' homes, a lone working procedure was employed<sup>19</sup>.

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<sup>17</sup> See Appendix H for a copy of participant consent form

<sup>18</sup> Transcription services were asked to sign a confidentiality agreement and data was transferred using a secure password protected Dropbox account.

<sup>19</sup> See Appendix I for details of Lone Worker Agreement

## **3.5 Procedure**

### **3.5.1 Recruitment of participants**

A number of recruitment strategies were employed. Initially, emails were sent to the Course Directors of the thirty UK based training courses, asking for permission to circulate an email to current trainees offering them the opportunity to take part in the research<sup>20</sup>. Email addresses for course administration staff were obtained from the Leeds Clearing House Website ([www.leeds.ac.uk/chpccp](http://www.leeds.ac.uk/chpccp)); the email was sent to these staff asking if the email could be forwarded to Course Director/s. Of the thirty courses approached, six courses responded and agreed to circulate a recruitment email,<sup>21</sup> they were located across a wide geographical area. Initial emails were sent to potential participants at these courses explaining the research, attaching the Information Sheet for the project and offering the opportunity to participate<sup>22</sup>. Fifteen potential participants replied to the initial email. Following email correspondence, ten were offered interviews; for five it was not logistically feasible to meet. Of the ten who initially agreed to take part, seven were interviewed and participated in the study.

Further recruitment emails were sent to Pre-Qualification Members of the Division of Clinical Psychology of the BPS (with permission from the Chair). Subsequently, a further five participants expressed interest in the study, and of these, two were recruited for interview. The other three potential participants were unable to participate because of time and availability restrictions. Further participants were recruited via snowballing strategies, whereby previous participants circulated information about the project to other trainees. Consequently, a further four participants took part in the project. Thirteen participants were recruited across six training courses. Many of these across courses in the South of England, with others in the Midlands.

### **3.5.2 Selected Participants**

Twelve participants were recruited to the study in twelve months. Consistent with GT and in order to theoretically sample, interviews were staggered across the year. This allowed for consideration

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<sup>20</sup> See appendix J for a copy of the email sent to course directors.

<sup>21</sup> Two further courses replied to the request but informed me that it was University policy that recruitment emails could not be sent out to trainees. Interestingly these two courses expressed an interest in the study, and both made suggestions for alternative recruitment strategies at their courses

<sup>22</sup> See Appendix K for a copy of the recruitment email sent to trainees

and analysis of each of the interviews before the commencement of subsequent interviews. The reality of doing this within the time-frame was difficult; due to participants being located in diverse geographical areas, participants were often interviewed in clusters dependent on geographical location. Following initial email contact with participants, telephone conversations were organised to discuss questions and make arrangements for interviews. Participants were asked if they would prefer to be interviewed at home or at a room within their University. Twelve participants were interviewed at home, and one at a University library. Participants were asked for some demographic information and information related to the type and duration of PT that they had received during training (Table 2). All participants were White-British, Irish or European, ranging in age from 26-31 years; only one male was recruited to the project. The sample shows little ethnic and gender diversity however, CPs are primarily female (estimated 80%) and 88.2% are of white ethnic origin (BPS: Clinical Psychology Workforce Project, 2015). This does, however, pose potential limitations to the project which are considered within the discussion.

**Table 2: Participants Information and Demographics**

Pseudonym	Age	Year of Training	Year of Training Started PT	Ethnicity	Number of Session	Type of Therapy	Theoretical Orientation	Previous Experience of PT
Sally	28	1	1	White-British	32 (ongoing)	Psychodynamic Psychotherapy	Integrative/CBT	No
Bryony	26	2	1	White-British	6 (completed)	Counselling (Psychodynamic)	EMDR and attachment focussed work	No
Lauren	28	2	2	White-British	20 (ongoing)	Intensive Short Term Psychodynamic Psychotherapy (ISTPP)	Psychodynamic	Yes
Jane	28	1	1	White-British	25 (ongoing)	Psychodynamic Counselling (1 <sup>st</sup> ) Psychoanalytic Psychotherapy (2 <sup>nd</sup> )	Psychodynamic	No
Brian	27	1	1	White-Irish	32 (ongoing)	Psychoanalytical Psychotherapy	Psychodynamic	Yes
Laura	29	2	Pre-training and throughout 1 & 2 year	White British	72 (completed)	Jungian Psychoanalytical psychotherapy	Dyadic Developmental Psychotherapy	Yes
Amy	29	2	2	White-British	36 (ongoing)	Psychotherapy	Integrative/Cognitive-analytic Therapy	Yes
Fiona	29	2	1	White-European	Unsure but more than 80 (ongoing)	Psychosynthesis	Integrative	Yes
Eve	31	3	2	White-British	35 (ongoing)	Psychoanalytical Psychotherapy	Integrative	No
Hannah	27	1	1	White-British	32 (ongoing)	Psychotherapy	Unsure	No
Donna	29	3	1	White-British	80 (ongoing)	Integrative - Psychodynamic with elements of CBT	Integrative	No
Jessica	30	3	1	White-British	Unsure estimated between 50-80 (completed)	Cognitive-Analytical	Integrative	No



### **3.5.3 The use of interviews**

Charmaz (2014) explains that when using GT, initial data gathering should capture rich data, which is detailed, focussed and full. Participants' views, feelings, actions as well as contexts and structures of their lives should be examined (Charmaz, 2014). Therefore semi-structured interviews were chosen which also allow the flexibility and structure to move iteratively between data gathering and analysis which is essential to GT (Charmaz, 2014). They permit data gathering in stages, beginning with open explorations of participants' stories of experiences, and later, following theoretical leads, interviews may be adapted to gather more focussed data.

### **3.5.4. Evolution of the interview guide**

An interview guide was developed in collaboration with the research team and refined after discussion within a GT workshop group, and following a pilot interview. This was a guide only not a series of set questions. The interview was designed around the research questions, and covered experience of PT whilst training, and PT and development in training. The initial informal interview guide included open-ended questions to elicit an initial broad view of key aspects of participants' experiences. Questions were asked slowly, with elucidative fillers offered to foster participants' reflections and directions (Charmaz, 2014). As concepts and categories were developed the interviews became more structured, to further explore particular aspects of participants' experiences. In an attempt to minimise preconceiving the data, the literature review was conducted after the majority of interviews had been completed and analysed. It is, however, important to note my knowledge of the research literature based on the literature reviewed for the research proposal. In an attempt to separate the initial interview schedule from my own knowledge and constructions of the topic, the initial interview guide was open and attempts were made to follow participants' leads to gather information related to their own experiences.

The initial interview schedule was used for the first four interviews. Each interview was analysed and the key ideas developing were influential in subsequent interviews. The constructed ideas from these early interviews helped evolve the questions and topics of subsequent interviews. For example, in interview one I understood that the participant worked through a process of contemplating using PT. The next participants I interviewed seem to work through a somewhat similar contemplation phase. Subsequently, the concept of contemplation

was explored in more detail based on the potential that this may be a key idea in participants' experiences based on interview ones and two. In subsequent interviews, if contemplation seemed to be discussed, there was a more in-depth exploration of what this process involved. Appendix L illustrates the development of the interview schedules following consultations.

The interview guide changed and evolved throughout the study as leads were followed up, adapted, or dropped from the developing model. Following the analysis of the first four interviews, six tentative categories of experiences were identified, and subsequent interviews aimed to ask questions around these developing ideas, whilst still remaining open to understanding unique experiences. Interviews four to eight, attempted to develop constructed categories, whilst remaining open to new experiences, ideas and processes. As sets of interviews were analysed, categories of experiences were adapted to incorporate new experiences, and subsequently, interview questions reflected these. Interviews nine and ten served to evaluate the key categories of experiences and the hypothesised processes that had been developed from the previous interviews. These interviews were therefore more formal and structured<sup>23</sup>. Interviews eleven and twelve aimed to explicitly discuss the tentative GT model developed from the previous interview, which was presented to participants for discussion. It would have been preferable to use focus groups as a method of testing the tentative GT model, however this was logistically unmanageable within the project's time frame.

### **3.5.5 The Interview Process**

Before beginning each interview I spent time introducing myself and the research project. I offered a space for questions or concerns about the interview process, as well as checking how much time participants had and letting them know that the interviews would take 60-90 minutes. On completion of the interview, participants were given the opportunity to reflect on the interview process and ask any questions. They were reminded that they had my details on the Information Sheet and could contact me or my research supervisor with any questions or concerns. All participants were asked if they would like a summary of the results once the project was completed.

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<sup>23</sup> See Appendix M and N for examples of the development of the interview schedule to test emerging findings from data analysis

Following the interview, I recorded my reflections in a reflective diary. Reflections included information on the tone of the interview, the ease of engaging in talk about PT, any feelings that I had experienced throughout, in addition to initial thoughts and ideas about the interview process. These reflections were important as they not only shaped the interview, but also impacted on my interpretations<sup>24</sup>.

### 3.6 Data analysis

The data was analysed using the principles and guidelines for constructivist GT outlined by Urquhart (2013) and Charmaz (2014). The process of analysis within this model begins with the interview, in which reflections and memos<sup>25</sup> are written soon after the interview has taken place. Interviews are then frequently revisited to familiarise oneself with the data. This involves repeatedly listening to recorded interviews. Memos may be developed throughout this process. Interviews are then transcribed, before analysis is performed. The key aspects of the process of analysis are outlined below, alongside reflections on the process.

1. *Interviews*: Following each interview, a reflective account was written of the interview process, and memos were created around key parts of the interviews that felt important or meaningful<sup>26</sup>. Interviews were then transcribed verbatim, with attention to all details including pauses, breaks, and any areas of the interview that felt emotionally poignant. Four interviews were transcribed using a transcription company.
2. *Initial coding*: The first five interviews were analysed using the initial coding principles of GT: line by line coding. This process involves line-by-line data fragmentation, and coding each segment with a label intended to capture the substance of what is being conveyed. In order to capture action within the data, it was advised at this stage of coding to use descriptive codes that could capture action, and therefore gerunds were used where possible. The purpose of initial coding is to closely read all data in order to remain open to any possible theoretical directions. The coding begins to make analytical sense of what is happening in the data. The idea is that codes at this stage stay close to, and grounded in the data, rather than being overly interpretative<sup>27</sup>. GT

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<sup>24</sup> See Appendix O for an excerpt of reflective diary following an interview

<sup>25</sup> Charmaz (2014) describes a memo as informal analytical notes, which can include the researcher's ideas, thoughts, or feelings on the interview process or aspects of the data.

<sup>26</sup> See Appendix P for an example of reflections and memo's from interview 001.

<sup>27</sup> Appendix Q provides an example extract of interview 002 provides an illustration of line-by-line coding

workshops were used to discuss initial coding and provided a peer reviewed process for doing so.

3. *Focused coding*: The next stage of GT analysis is focussed coding. This involves reviewing initial codes that occur frequently, or codes which appear significant in portraying meaning. The initial codes that had been generated across the first five interviews were reviewed and important or frequent codes were pulled up to focussed codes. A document was created of comparative focussed codes across the five interviews, however focussed codes were also created for each interview. During this process memos were used to try and illuminate the processes that I was constructing from the codes. I created a document with focussed codes, initial codes, and memos and quotes from the data ensuring that I understood processes as they related to the data<sup>28</sup>. Focussed coding allowed me to begin to develop key ideas about what I felt was happening in the data. Once focussed codes were developed, they were used to analyse the remainder of the interviews; as the interviews were analysed against these codes, the codes were constantly refined and developed. Thus, the process of analysis involved constant comparisons across data sets.
4. *Developing and Defining Categories and Subcategories*: Once I had completed interview six, I began to synthesise focussed codes into tentative conceptual categories and subcategories and aimed to identify the theoretical direction of the results. This involved looking at how focussed codes fitted together under higher conceptual categories, which helped in how I was constructing what was happening in the data. Focussed codes that I felt explained key ideas or processes were elevated to categories or subcategories at this stage. For other clusters of focussed codes a category was developed which hoped to give a theoretical description of the codes and data<sup>29</sup>.
5. *Theoretical coding*: Theoretical coding is an advanced level of coding that follows the codes selected at focussed coding, and the categories developed from these (Charmaz, 2014). It involves describing how categories relate to one another as predictions to be integrated into a theory. The idea of these codes is that they integrate the data that has

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<sup>28</sup> See Appendix R for an example of focussed codes, initial codes and related memos

<sup>29</sup> See Appendix S for an example of the development of categories from initial/focussed codes

been constructed in order to tell a coherent analytical story (Charmaz, 2014). In doing this, relationships between categories are identified under theoretical concepts which help to explain the data. These codes are aimed at explaining processes. The move to theoretical coding was aided by returning to memos, and developing new memos that began to consider hypotheses about the processes involved in participants' experiences of PT, and how these related to development. Several hypotheses were generated at this point, and each interview was reviewed to establish if these theoretical links were able to explain the data. In order to aid this process, many differing models were drawn out to try and understand links and connections between categories<sup>30</sup>. The final GT model described is the one which was felt to explain the majority of the data, and the one in which theoretical codes and concepts were found to account for this data.

6. *Memo writing*: Memos were used throughout all the analysis, and marked an important process of GT. Memos were used to ask myself about developing ideas, and tentative hypotheses about processes occurring in the data. Memos were helpful in comparing and contrasting ideas across interviews and in guiding the theoretical direction of the analysis. Memos also served as a data trail for developing ideas and theories constructed over the course of the research. A collection of memos can be found in Appendix U, illustrating the development of a key category.

### **3.7 Credibility, Rigour and Relevance**

The criteria for assessing the quality of qualitative research differs to that of quantitative, in which there is a focus on validity, reliability, and objectivity (Mason, 2002). Within qualitative designs, quality is measured in terms of the rigour and credibility of a study (Yardley, 2014; Elliot et al, 1999). The strength of qualitative research is measured against criteria such as sensitivity to context, commitment and rigour, coherence and transparency, owning one's perspective, and the usefulness of the research (Yardley, 2014; Elliot et al, 1999). Throughout this research I have attempted to ensure that these criteria have been met. A brief summary of how this has been done will now be provided<sup>31</sup>, and returned to within the context of the Discussion.

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<sup>30</sup> See Appendix T for examples of model development

<sup>31</sup> For tabulated example of how this research has meet quality criteria in Appendix V

Attention and sensitivity to context has been ensured through the explicit descriptions of the context in which the study has been developed throughout the introduction. Ownership of my epistemological position and personal reflections on the use of PT during my own training provide transparency and allow the reader to judge my perspective. Throughout all sections, my own personal context has been described and consideration been given to how this may impact on the study. Contexts that may impact on how participants experience PT has been considered within the analysis of the results. For example, a smaller process model of how participants make the decision to use PT has been provided, as this sets the context for subsequent experiences and potential developments within PT.

Credibility and rigour have been demonstrated in a number of ways. Firstly, member-checking was used in the early coding of data, in both GT workshops, and with another researcher who double-coded a transcript. Consistent with my epistemological position, it is assumed that different interpretations may be both useful and valid. The aim of member-checking was to explore alternative constructions and my own biases, rather than striving for reliability of codes. A thorough description of the stages taken in analysing the data is provided above, alongside reflections and accounts of these processes further demonstrating transparency. Within the discussion data constructed from the results of this study have been triangulated with data from other studies and provide some support for the credibility of the findings. In line with suggestions by Elliot et al. (1999) during the process of analysis, emerging ideas and concepts were discussed in supervision to test coherence and their adequacy in describing the data. Supervisors reviewed the Results section to ensure that the theoretical concepts and categories made sense and were grounded within the data. Quotes have been used throughout the Results and Discussion to highlight links between the transcript and the interpretations made. A section of transcript, with example of codes and related categories is provided in Appendix V. Details related to concept developments are illustrated in Appendix Q and R. These steps, taken to ensure quality, allow the reader to judge for themselves the credibility, transparency, and rigour of the study.

The pragmatic usefulness of research as well as its power to inform future research or clinical practice is another important consideration of qualitative research (Riessman, 2008). Throughout the research process this has been considered and is explicitly commented on in

Chapter 2 (2.5) and the Discussion (5.5). Attempts will be made to disseminate the research through peer-reviewed publications, presentations at appropriate conferences, and through the DCPs' pre-qualification group to increase utility.

### **3.8 Self-reflexivity**

As discussed, within the context of constructionist GT it is vital for researchers to engage in reflexivity at a number of levels. I have begun this process within the Introduction (1.2), and continued this throughout each Chapter. I return to reflections here to discuss how I feel my own experiences may have impacted on constructing meaning throughout the analytical procedure and subsequently influenced my relationship to the current research.

*I explicitly positioned myself within the research as a Trainee CP using PT. I am therefore linked with participants in the process that I am studying. There are similarities and also much difference in our experiences,<sup>32</sup> and my own experiences of PT relate to some aspects of the models constructed whilst not for others. My experiences share something with participants Laura and Lauren. Laura and I have a similar social background, experiences and management of our own emotional wellbeing, which I feel made us more aligned in our values and perspectives. Lauren described difficult emotional experiences in parts of PT whilst training which resonated with me. I intentionally analysed these two interviews last, once I had constructed tentative categories of the results. By testing how these interviews fitted with the rest of the data I hoped not to overemphasise meaning from our shared experiences, but instead to see how this meaning fitted with data where my own experience felt further removed.*

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<sup>32</sup> See Appendix X for example of reflective account of how my own experiences fit with the developed model.

## CHAPTER 4: RESULTS

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### 4.1 Overview

The aim of this chapter is to provide an interpretation of the data derived from twelve trainee CPs' experiences of PT whilst training, and how that may have related to their development, using grounded theory analysis<sup>33</sup>. It presents my own construction of the phenomena under study. Another researcher may have observed similar processes but constructed and understood these differently. Examples of how I constructed the model of participants' experiences, with examples of initial codes, focussed codes, and emergent categories and concepts are provided in a series of appendices<sup>34</sup>. This should enable the reader to perform their own credibility checks (Elliott et al., 1999). Participants' quotes are provided throughout to illustrate the findings of the analyses<sup>35</sup>. For ease of reading and clarity these have been edited<sup>36</sup>. The models constructed from the data and the higher order results are initially presented and summarised. This is followed by a detailed description of each model's component concepts, and the categories and subcategories which occur within, alongside a summary of each.

### 4.2 Summary of Results

#### 4.2.1 Models and higher level results

The models constructed from the data analysis are presented below. Figure 1 represents my understanding of the process by which participants made the decision to access PT, represented by the concept 'Making the Decision'. I included this as it was considered key to participants' experiences, and it provides a context as to participants' experiences and development within PT, which is depicted in Figure 2.

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<sup>33</sup> Reflections are denoted in italics throughout this chapter

<sup>34</sup> See Appendix 7.4, Section 4, for examples of aspects of the analytical process

<sup>35</sup> All participants, were given pseudonyms to maintain anonymity, and all identifying information was removed.

<sup>36</sup> The verbatim quotes in this section have been edited to improve readability... indicates that words have been removed from the extract, () indicates that researchers words have been removed from the extract, [] indicates that the researcher has added text to assist with meaning, repeated words, hesitations, and umm's have been removed.



### ***Model 1: Making the Decision to use PT***

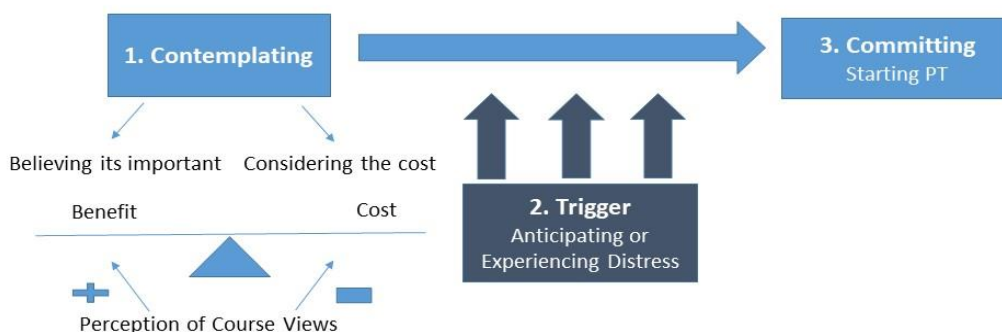


Figure 1: Model 1: ‘Making the Decision to use PT’

Figure 1 describes how I have understood participants moving from contemplating PT whilst training, which involves weighing up the benefits and the costs, to committing to it. Consideration of the perceived costs and benefits can be influenced by how participants perceived training courses viewed the decision to access PT. Those who understood that their training courses may perceive accessing PT in a more negative light were more likely to contemplate the costs, whilst those who perceived that their training courses may encourage accessing PT, seemed more likely to consider the benefits. Movement from contemplation to commitment is mediated by a trigger which I have conceptualised as experiencing or anticipating distress. Participants continue to weigh up the costs and benefits of using PT whilst training throughout the experience. Model 1 makes way for Model 2 (overleaf), which depicts how I have understood experiences within PT.

## ***Model 2: Experiences and Development in PT***

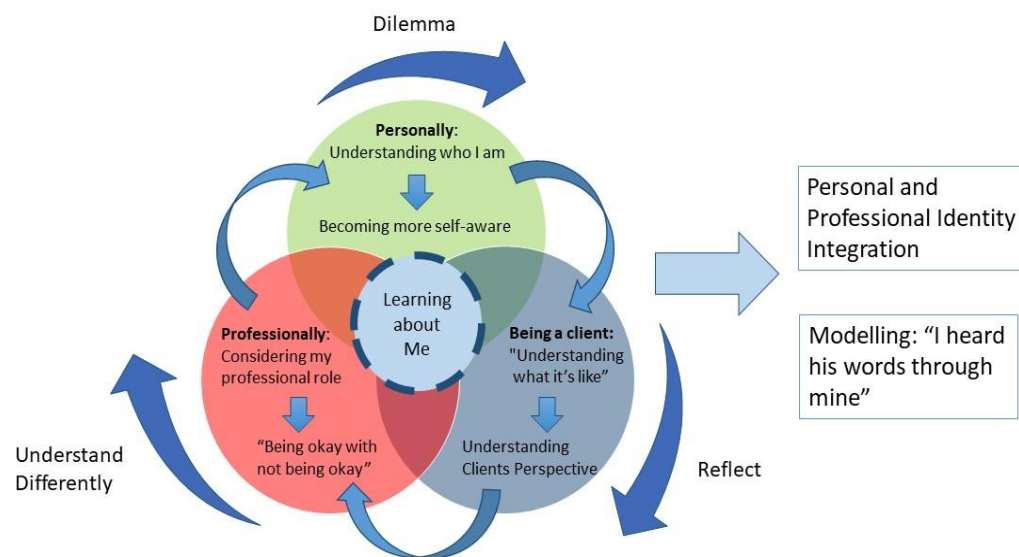


Figure 2: Model: Experiences and Development in PT

Figure 2 represents how I have understood participants' experiences of PT, and how these may relate to their development. The central concept of the model represents what I have understood to be core to participant's experiences in PT: 'Learning about me'. Participants seem to develop and learn about themselves across the three conceptual domains; 1) Learning about me: Personally; 2) Learning about me; Professionally; 3) Learning about me: Being a client. I have understood that development in these domains happens through the continuous process of participants taking a dilemma related to one of these domains to PT, reflecting upon this, and, having reflected, evolved a different way of understanding these aspects of themselves.

As participants learn about themselves and experience being a client, this impacts on how they understand themselves personally and professionally, which subsequently impacts on their experience of being a client. Through these experiences, I have understood that participants develop in their self-awareness, begin to develop in their professional identity, model positive aspects of their own PT, and are better able to bridge the professional and personal aspects of themselves. Importantly, participants continue to weigh up the costs and benefits of PT throughout, particularly at times when the experience of being in PT is more difficult. The models will now be described in further detail alongside participants' quotes.

### 4.3 Detailed Results

#### 4.4 Model 1: Making the decision

The process of making the decision to access PT is made up of three concepts: 1) Contemplating, 2) Trigger, and 3) Committing to PT (starting PT). The concept Contemplating is made up of three categories<sup>37</sup>: *Considering the benefits*, *Considering the costs*, and *Perception of Course views*. Considering the benefit has two related subcategories: *Believing it's important*, and *Understanding myself better*. The concept Trigger has one category, *Anticipating or experiencing distress*. These will now be discussed in turn.

##### 4.4.1 Contemplating

The category 'Contemplating' describes how I have understood participants considering whether to use PT whilst training, as described by Jane.

Prior to the course I was thinking about having therapy and so when I knew I'd got a place and I was thinking I'm looking forward to starting and also starting therapy (Jane)

I have understood that as participants contemplated PT, they worked through a process of thinking through the benefits and costs, and that a number of factors may have impacted on the process of making the decision to use PT. It seems that thinking through the benefits is driven in part by participants believing PT is important to training (*Believing it's important*), primarily to learn about themselves (*Understanding myself better*). It appears that participants also consider the costs of PT at this stage (*Considering the costs*). Participants' decisions appear to be influenced by their perceptions of how their course views accessing PT (*Perception of Course views*).

##### 4.4.2 Considering the benefits

###### 4.4.2.1. *Believing PT is important.*

Most participants spoke of believing that PT is important to training, and many considered why it is not a mandatory part of training:

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<sup>37</sup> Throughout this chapter Categories and Sub-categories of the models are depicted in italics

...I yeah always thought it was really important that I'd like to do it and I also always thought that it was strange that it wasn't mandatory actually in terms of clinical psychology. (Brian)

This appeared to lead participants to consider using their own PT whilst training. I have understood that for many participants believing that PT is important to training is connected to an idea that having a better understanding of oneself is important to working clinically. These ideas make up the sub-category: *Understanding myself better*. For most participants this was a motivating factor in deciding to use PT, and the idea that it is important to training seems to be reinforced through experiences within PT.

#### 4.4.2.2. *Better understanding myself.*

Participants talked of the importance of having a better understanding of oneself, and one's own history, as this could help in understanding what they may contribute to encounters with their own clients. For Laura and Lauren there was an explicit idea that they needed to understand their own emotional difficulties in order that these did not interact with clinical work:

I do think that if the skeleton is in your closet that actually you would be a better psychologist if you had faced them... (Laura)

Others talk less about understanding experiences of their own emotional difficulties, but more of gaining a better understanding of themselves, and their interactions with clients, believed to be beneficial to clinical work:

I do think it helps you in terms of thinking about your reaction to clients; whether that's something about you or whether that's something about them. (Laura)

I always thought that surely what, surely you'd be, surely as a therapist you're guided, and you're guided or errrr, pushed away from things that are very evocative for you... (Brian)

Amy talked of wanting to understand herself better, in order to understand her behaviour in relation to clients and colleagues, suggesting that understanding herself better could impact on her clinical work and her training relationships more widely:

Yeah, I think when I started, my aims were I guess around exploring, understanding myself better which I think would help me clinically... so help to know how I am, why I am a certain way with certain people, with patients for example, why it's hard for me to stick to boundaries, and to stick to time and to understand my relationships with supervisors and colleague. (Amy)

As shown, I have understood that the participants hold shared beliefs that PT is an important part of training, as a means of facilitating a better understanding of self, and to be beneficial to relationships with clients and the training process. However, it seems that whilst contemplating PT, participants are also considering the costs.

#### **4.4.3 Considering the Costs**

Participants considered various costs associated with accessing PT. Jane talked about the practicalities and financial costs, something which many other participants considered:

Then, other questions kind of came up about cost and stuff what I was willing to pay, when I was available, and at each of those questions, I kind of paused again, so I knew that this was something I wanted but each of those kind of queries slowed me down a bit. (Jane)

Whilst Eve considers training related practicalities:

Yeah, so the thing I found was because of where I was living and because of where I was at placement and moving around lots it was quite hard to commit to a therapist. (Eve)

It seemed that there were more implicit considerations about the emotional costs of PT, with participants feeling nervous or worried about what PT may have involved. Sally talked about this, but, as she described it, there is a sense of embarrassment in feeling nervous or apprehensive about PT. I have understood that for Sally it seemed easier to use the practical costs as a reason for not engaging with PT. This is mirrored in other interviews, and raises interesting questions about potential barriers to trainee CPs accessing PT, and how easy it is to talk about these.

And I think it was more (pause) it wasn't just that I just hadn't got round to doing it, I was a bit, sort of nervous, I didn't know what to expect (Sally).

#### *4.4.3.1 Perceptions of how course view PT*

The way in which participants perceived their courses viewed trainees using PT whilst in training, seemed to impact upon how they contemplated the decision to use it. For some participants there were explicit messages of encouragement. As Jane described:

We had an induction talk with the head of the course and he was like oh we strong, I don't think they said strong they said, they said we encourage you to have PT as part of the course it's not a requirement but it can be valuable (Jane)

She goes on to talk about how she feels this facilitated her making the decision:

It's something that could easily be darted around, or brushed under the carpet or thought oh that's two hundred pounds I should be saving... that kind of thing... no I think having, an open conversation about it is helpful... (Jane)

I have understood that at training courses in which PT is either encouraged or openly talked about, that the decision to access PT appears somewhat easier.

Yeah they said a couple of times near the beginning that it's not compulsory... But a lot of, quite a few sort of tutors have actually said themselves that they've had PT themselves and they've found it really helpful... And yeah some people have been explicit and say yeah I think it should be compulsory"... Yeah so it was kind of like, I was influenced [the decision] by the course (Sally).

For other participants there was a perception that training courses may be discouraging of using PT whilst training, seemingly because it wasn't talked about. As Bryony describes

I think it's not something that's kind of encouraged... I suppose if they don't encourage it, it makes it feel like it's discouraged but actually it's not, it's just, they don't really have an opinion on it I don't think (Bryony)

Lauren described feeling that the course was in fact discouraging of PT:

It was an important decision for me. And I guess rightly or wrongly it's not something that the course thinks about or helps you to think about, or supports you with... Yeah I feel a bit cruel saying this about the course, I guess as a whole they say we would prefer if you didn't (Lauren)

I have understood that it is more difficult to make decisions about accessing PT for participants like Lauren and Bryony, who attend courses perceived to be discouraging of using PT. As Bryony goes onto describe:

I guess worrying about, I guess linked with the course, kind of worrying like, if I'm asking for therapy does that mean that they think I'm not coping. (Bryony)

It seemed then that how courses are perceived to view the use of PT by trainees may well impact on trainees decision making.

The contemplation stage of making the decision to use PT seemed to involve a weighing up of both the benefits and costs of PT. It seemed that the way in which courses are perceived to view trainee's use of PT impacted on decision making. Participants at courses which didn't encourage or seemed to discourage PT seemed to find the decision more difficult. Participants who perceived their courses to encourage the use of PT, seemed to be less focussed on the costs, perhaps facilitating making the decision to access PT. Interestingly, some participants talk of how, when considering PT, it would have been helpful to have some input or support from the course in thinking this through:

I certainly would have appreciated a lot more support 'cos I felt like I was doing something, yes for me, but also for my profession and my career. (Laura)

And I think I really could have done with some help I think. I feel a little bit frustrated that you're not supported a bit more in that endeavour, if that makes sense, I think by the course. (Eve)

For other participants, this help was provided and was valued:

I guess at that point that was when, you know, I was probably contemplating, then they gave us kind of a talk about, kind of what, what we could do, how we could access therapy.”  
(Hannah)

It seems however, that whether there was support from courses in thinking about PT or not, participants needed a trigger to start PT.

#### **4.4.4 Trigger**

##### *4.4.4.1 Anticipating or experiencing distress*

Many participants talked about using PT to help them cope emotionally with distress engendered from the process of training. When I asked questions about what had motivated their decision to use PT, most talked of believing that it was an important aspect of training. It seemed however, that feeling or anticipated distress may also have acted as an impetus for participants moving from contemplating to committing to accessing PT. For Jane and Lauren training had begun to have quite an impact on their self-esteem, leading to distress and facilitating in them deciding to access PT:

Yeah I guess I was struggling a little bit with who I was. I was finding the course really, really hard... It had quite a big impact, I guess probably around my self-esteem at that point and I just was thinking, oh shit I can't keep up with this... I was, like, I can't feel like this for much longer, I hate this, let me do something about it... (Jane)

I think more that the course () was very triggering, and the pressure, and the consistent need to prove yourself... very much played into my beliefs about myself... And I was just quite unhappy, quite anxious... (Lauren)

Brian talked of feeling distressed at the outset of training and this being an impetus to begin PT:

I was a bit distressed..., I think that's actually, yeah, that was the impetus... I was distressed and that made me go a bit faster. (Brian)

Eve talked of finding managing the demands of the course, alongside a difficult placement stressful and of this acting as a trigger:

I found second year quite a bit more emotionally gruelling, not necessarily the content but I think definitely the demands on my time, and that's when I decided to seek someone out... (Eve)



Others who started PT from the outset of training explained how they had done so as they had anticipated needing emotional support whilst training. Both Sally and Fiona talked of hearing about the course being stressful, and of this contributing to setting PT up at the outset:

And then the course started and I felt like ok let's get this sorted out, put it back in place knowing of how tricky and difficult the course can be and what people have said, and just getting my support network in place...(Fiona)

Some participants commented on wishing that they had used PT before getting to the point of being distressed. Participants' experiences of needing support to manage the impact that training was having on them, links with the concept *Learning about me professionally*. For many participants it seems that the decision to use PT was related to struggle or distress related to being in the role of a trainee. It seems that PT was used in part as a space to consider how this relates to developing a professional identity:

I think there's probably like a foundation of it running through [PT], this idea of being a trainee... (Eve)

It is important to note that Laura and Bryony, felt that PT was a way of helping them to cope with experiencing emotional distress that was not explicitly related to training.

Whether participants were experiencing distress related to the course, were anticipating that the course would be stressful, or had other experiences impacting on their emotional wellbeing, it seems that anticipating or experiencing distress acted as a trigger for participants to make the decision to commit to accessing PT.

#### **4.4.5 Committing to PT**

I have understood that in starting PT participants made a commitment to the process. At times the process of PT was difficult, and participants seemed to return to contemplating its worth, and whether the benefits outweighed the costs. However, it seemed that even at these difficult times that there was still some commitment to the process:

I have really mixed feelings about it, on the one hand I hope that it will make me more authentic, but at times it makes me feel like absolute crap and that like I am not really functioning very well, but you know I don't know if I would feel like that anyway, so yeah just really mixed you know mixed but committed. (Lauren)

I think that I continued to kind of weigh it up throughout really, I guess there were times when it was just hard, and I didn't want to go, and then I probably started thinking about if it was worth it, but by that time I was distressed so then it seemed better to carry on than to not. (Jessica)

#### **4.4.6. Summary**

Model One describes how I have understood participants' decisions to use PT, moving from contemplating to committing to it. As outlined, participants seemed to contemplate PT because they believed that it was important to their professional development and to understanding themselves. They also considered the costs. Core to how I have understood participant's experiences within PT is '*Learning about me*'. It may be that this motivation for self-understanding at the outset of PT leads participants to explore aspects of themselves throughout their experiences within therapy. Experiencing or anticipating distress related to being a trainee often acted as a trigger to participants accessing PT. This may subsequently impact on participants using PT as a space to learn about themselves professionally, as they consider the role of being a trainee within PT. The process of making the decision to use PT seemed to impact on experiences and development within PT, which will now be discussed in presenting the results of Model Two.

#### **4.5 Model Two: A Model of Learning**

Model 2 represents how I have understood participants' experiences and development in PT. I have understood that core to participants' experiences in PT is learning about the self (*Learning about me*), and the model represents how participants have learnt about themselves throughout their experiences of PT. The issues explored in PT by participants centre around understanding the self, both personally; '*Understanding who I am*' and professionally; '*Considering my professional role*', which make up two of the core conceptual categories of how participants learn about themselves. The third conceptual category is '*Being a client*' which seemed to involve learning related to being in the position of a client. It seemed that participants learnt about themselves in the position of a client and appeared to apply what they learnt from these experiences to their personal lives and professional practice. I have understood that through

exploring and learning about the self in these ways participants developed greater self-awareness, that they felt able to model helpful aspects of their own PT, and that personal and professional aspects of the self were more able to be integrated. It seemed that learning and development across these domains are explored through the process of experiencing a dilemma which is then reflected on in PT; through the process of reflecting on the issue, participants come to understand it differently. This constructed process will now be outlined using examples, followed by a detailed description of each conceptual category and its component parts.

#### **4.5.1 The process of learning about me.**

I have understood that participants reflect on dilemmas in PT (See Figure 2 for graphical representation). These may be training-specific or related to other aspects of life:

And I kind of talked about that dilemma and thought about it and how I should of talked about it at the beginning and said no, I want to say, I want to be up front about it... and just sort of managing the dynamics, the power dynamic between me and my supervisor. (Sally)

But it's not quite what I want out of supervision... I brought that recently to therapy... (Fiona)

... mainly we talked about the current stuff that was going on.... and then the kind of struggling through the court case... (Bryony)

It seemed that participants were aware of something that they were struggling with or experienced as dilemmas and they brought these to PT, at other times it seemed that they realised or become aware of a dilemma or difficulty through talking about issues or experiences in PT which highlight these:

Sometimes I don't even realise that it was a dilemma and it just sort of comes up... (Fiona)

It seems that as participants reflected on these dilemmas within PT that they subsequently came to understand them differently. This process is illustrated below when Sally explains how she came to understand a difficulty she was having in a group exercise:

I learnt [In PT] that I am quite kind of vocal in groups and quite kind of... sort of like a bit bossy and I try to kind of lead group... And it was a sort of struggle in me, Oh God, I don't want to be overpowering... (Sally)

She reflected on the possible reasons:

In therapy I was sort of thinking about where that came from... we were thinking oh why and sort of went back and back and back and sort of worked out that when I was younger my parents they both worked sort of went back to work... and I was quite a sort of distressed baby... and we were sort of wondering whether you know when I got to sort of nurse and school and I did well and that was a way that I then got attention that I wanted from my parents...(Sally)

And she came to understand it differently:

I have to get good grades, and mmm, this is how it, why this means so much to me like that we have to do well on this we have to. It's because it means to me that then I'll get the praise and kind of attention that I want from my parents...I've kind of worked out that was (pause) where the anxiety was coming from. Which was really useful to sort of relate to how I was being in the group... (Sally)

Bryony talked about working through a difficulty that was re-occurring for her in the context of her personal relationship, of reflecting upon this, and understanding it differently. She subsequently tried to adapt her behaviour:

My relationship with my old partner ended up breaking down... Probably because I was keeping a lot to myself and probably taking a lot out on him... and just kind of reflecting back on that has made me think oh that's not useful to both hold your own emotions... that's been really useful actually, it's kind of, I think we probably would have ended up breaking up... It's been yeah a new experience for me because I don't, didn't used to tend to do that. I think that probably has helped through therapy because she helped me kind of link experiences from childhood and wonder what other relationships how that might come out... (Bryony)

I have understood that participants have an experience of learning about themselves through continuously working through a process of bringing or discovering a difficulty or dilemma in PT, reflecting on this, understanding it differently, and then making changes

which may lead to a different outcome. This process can be seen in how participants learn about themselves personally.

#### 4.5.2 Personally: Understanding who I am

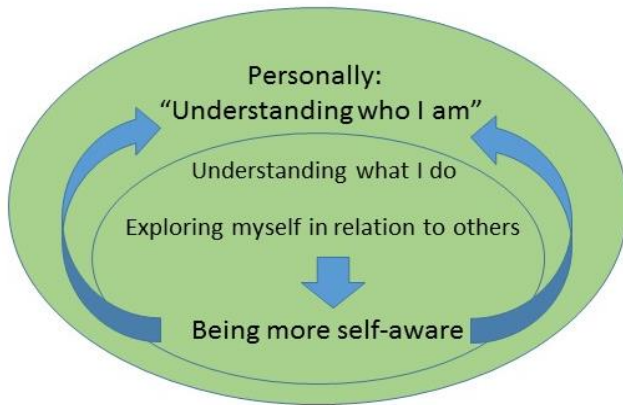


Figure 3: Concept: Learning about me: Personally

This core category relates to participants' experiences of learning about themselves personally within PT. It is made up three subcategories; 'Exploring *myself in relation to others*', '*Understanding what I do*', and '*Being more self-aware*'. I have understood that participants come to better understand who they are by exploring how they relate to others (*Exploring myself in relation to others*), and by better understanding their behaviour (*Understanding what I do*). It seemed that through understanding themselves through these processes, participants developed greater self-awareness (*Being more self-aware*). Laura and Eve talk of why they feel that this personal exploration is helpful to training, which I feel conceptualises how many participants felt. This relates back to how I have understood that participants believe that PT is important to training, facilitating them making the decision to commit to accessing it. It seemed that through learning about themselves personally, participants had more conviction in this idea:

Otherwise you can go through the whole of training without really having to think about your own history and your own interpersonal style, or you know if you're not forced to, you might choose not to... (Laura)

Everyone else has a past, no one was born a psychologist. You have all this other stuff that happens to you... And that idea that not every single person will have taken time to think back and look at that... that seems to me really weird. I don't think that makes any sense. (Eve)

Surely as a therapist you're guided, or pushed away from things that are very evocative for you, all of which you may not realise and have a handle on in a very conscious way. I always thought that that would be an essential thing to try and untangle [in PT]. (Brian)

#### *4.5.2.1 Exploring myself in relation to others.*

I have conceptualised that participants learnt about themselves personally via a process of understanding aspects of how they are in relation to others. It seemed that participants came to better understand themselves and who they are by reflecting on how they interacted with others. Jane talked about understanding herself in relation to her cohort and why she clashed with certain people, helping her to understand what it is about her that makes interactions with certain people more difficult:

It's definitely helped me think about my cohort and my place within my group... there are people that I clash with so I've used it to kind of think about reasons why... (Jane).

Brain talks of having a powerful realisation of what he was finding difficult about interactions with certain people, and how this related more to him and his past than to what he had perceived was happening in the interaction:

I realised that actually I'd been operating with quite a few people, where sometimes people would say something and I would get a feeling and actually the feeling was more in the transference of the interaction, what I was bringing say pushing onto them. (Brian)

Amy talks of understanding her difficulties with asking for help through thinking about how she is in interpersonal relationships:

This [PT] helped me to think about it in an attachment way that I'm quite avoidant of I just try and get on with things myself so in a interpersonal relationship I don't ask the other person for help I just expect myself to be able to do things (Amy)

It seems that participants also learnt about themselves personally though exploring why they may behave in certain ways.

#### *4.5.2.2 Understanding what I do.*

I have understood that participants also developed a better understanding of themselves through reflecting on the things that they do, helping them to better understand themselves. Eve talked of how PT provided an understanding of her motivations for acting in certain ways, facilitating her in having a better understand of herself:

The therapy experience has helped me think about my motivations for acting the way I am... I think that's been really helpful... I think it's about that opening up of different ideas about why you do the things you do... (Eve)

Bryony talked of being better able to notice and understand some of her behaviours:

...being aware of my tendency to kind of hold things in and block people off then take it out on them, it's been quite useful to be aware of when I'm doing that... (Bryony)

Sally talks of understanding how difficult she finds it to be in a vulnerable position, leading her to focus on helping others:

...it's something I actually talk about in therapy is how I tend (pause) to sort of try to like, focus on helping other people as way to defend against asking for help myself and then kind of being in a more vulnerable position... (Sally)

I have understood that as participants learn to understand themselves through these processes that they develop in self-awareness.

#### *4.5.2.3 Being more self-aware.*

Learning about the self through exploring relationships, and behaviour appears to lead to participants developing greater self-awareness. Amy talks of developing more of an awareness about her difficulties asking for help:

... and it made me think a bit more about what I have learnt about myself in therapy and it helped me to fill out that on the form and bring that up and discuss that with him... and he said that is

really good for me to know and we can keep thinking about that in supervision, and it was just helpful to have those conversations, so it helped me to bring up things that I otherwise I don't think, I kind of new that about myself... (Amy)

Laura described feeling like one of the most important parts of her PT was in developing an awareness of things that she didn't know about herself, and how this has helped in her personal and professional life:

Yeah I think that's what the benefit I guess was for me is actually uncovering things that I wasn't necessarily aware of. (Laura)

For some participants, becoming more self-aware seemed to allow them to have more choice about how to behaviour. Sally described this:

I have choice, do I play into it or not. Yeah it brings it back to that element again of having awareness and then having choice from awareness. I notice when I am doing that...

Researcher: And now you kind of notice it do you do anything differently

It's sort of a choice now and sometimes I choose to do it anyway and sometimes I stop myself" (Sally).

Some participants described how the self-awareness that they developed helped them to better differentiate between their own emotions and others, as Jane described:

Like these kind of lightbulb moments of what's mine and what's not mine and those distinctions so, not having to own everything I feel. (Jane)

Others talk of having greater reflexivity in understanding what aspects of themselves may lead them to interpret situations with clients differently. Laura conceptualises this idea:

It comes back to that knowing what's yours stuff, that's what I mean.... Are these questions about my curiosity or are they actually about informing the formulation and then when it comes to the formulation you know reflecting on why have I added that in and why have I left that out. (Laura).

Many participants also commented on the possible impact on their coursework and grades:



I got one of the highest marks I've ever got on the assignment, in the sort of reflection and I don't know if it helped me with the assignment in itself, but in terms of the process and the reflection it really helped" (Lauren)

It seemed that participants' experiences of learning about themselves personally through exploring relationships and behaviour may have helped them in developing greater self-awareness. This subsequently may have impacted upon their relationships, personally and professionally. Amy and Bryony talk of the impact this learning had in the context of their relationships with partners, and Hannah, Sally, Brian, Fiona with friends, and Eve with family. It seemed that this process also impacts on participants' professional development in terms of them shifting how they understand their client work, and relationships with supervisors. Participants also appeared to have learnt about themselves as professionals through an exploration within PT of their developing professional identity.

#### 4.5.3 Professionally: Considering my professional role.



Figure 4: Concept: Learning about me professionally

This core concept relates to participants' experiences of learning about themselves professionally, by reflecting on their professional role. I have understood that this impacts on their views that good psychologists do not have their own emotional struggles. The core concept is made up of three subcategories; '*Reflecting on professional context*', '*Feeling I have to be okay: fearing judgement*', and '*Feeling okay with not being okay*'. It seemed that at the outset of PT participants considered their professional role as a Trainee CP (*reflecting on*

*professional context*). As part of these reflections participants talked of feeling that it was unacceptable within the profession for a trainee to be struggling emotionally (*'Feeling I have to be okay': fearing judgement*). As participants reflected on this in PT, it seemed that they become better able to accept struggling emotionally (*being okay with not being okay*). I have understood that through this process participants come to reconceptualise their professional role, and identity.

#### *4.5.3.1 Reflecting on the professional context.*

In understanding their professional role within PT, participants reflected on the professional context that they are situated within. Many participants initially talked of feeling a consistent need to prove themselves, and having a sense of a professional identity which as Sally described perpetuates needing to be “superhuman”. Eve and Sally talk of how these expectation impacted on their sense of professional identity:

You feel like you, or I do anyway like I'm a trainee and I have to be fine and I have to be okay I have to do everything really well and be great on placement...(Sally)

Others described feeling that there is not enough of an acknowledgement or appreciation that trainees and professionals could experience their own emotional difficulties. Hannah described this:

There's no recognition that people in the room might find things difficult ever or could have their own personal experience and that kind of reinforces the idea that I'm not supposed to feel anything, I'm supposed to just be fine all the time. (*Hannah*)

Brian speaks of a similar experience and of feeling like this created a distinction between oneself as a professional and client:

It says well we, well you're on training you got here it's really hard to get here so obviously your genetically endowed to be superior or some absolute nonsense you know. You'll never be anxious but for the patients you see who have this whatever, disorder, then you need to do whatever. (Brian)

Some comment on how they understood this lack of acknowledgement of trainees' potential emotional struggles, and how the way teaching is set up has led them to believe that the profession is "emotion phobic". Amy talks of this perpetuating an idea of a divide between an emotional and professional self:

Sometimes it feels like, we do reflect and stuff but sometimes I feel like we really don't connect with our personal experiences or our own mental health or life experiences. It feels very like that is separate and this is work. Even sometimes like in lectures just a word of warning this may touch you personally and feel free to leave the room, and so it's kind of a clear message of don't bring your personal life into this... take that away and manage yourself and come back when you are composed. (Amy)

It seemed that these ideas about what it meant to be a trainee impacted on participants' concepts of professional identity. This seemed to create a context in which participants' struggled, as they attempted to meet these perceived professional expectations, and for some grappled with how much of themselves they could bring to their professional role. I have understood that this contributed to participants feeling that within the professional role it isn't acceptable to struggle with emotions. Subsequently it seemed that participants feared professional judgement for these experiences.

#### *4.5.3.2 Thinking you've got to be okay: Fearing judgement*

In thinking that it was necessary to be free from emotional struggles, participants talked of fearing judgement from the course, peers, or their own judgement of themselves for needing support. Sally and Bryony express these concerns and also questioned whether a CP should have their own emotional difficulties.

So there was that fear of judgement or like or you know someone who wants to be a psychologist shouldn't feel like that (speaks in a quieter tone), shouldn't have that kind of mmm, I don't know difficulty I guess. (Sally)

I guess probably that anxiety around, you know as a therapist you should be like, like kind of having that preconceived view that you should be ok all the time, kind of thinking that, you know that you've got to be ok all the time. (Bryony)

Lauren described a perception that you should be able to handle your own problems, and of the impact of comparing herself to trainees who were perceived to be coping:

“I don’t know if there is more acceptance in this world or if actually you’re supposed to be, like above it or able to sort of sort problems out on your own or something... I think what’s wrong with me that I can’t cope like everybody else, and what’s wrong with me... (Lauren)

Participants expressed the value of having PT as a space to consider the impact of these perceptions and expectations of the professional role. Jane describes how PT helped her to make sense of this:

It helped me think about why I was having a tough time... and just helped you know, me notice the ridiculous pressure I put on myself, which I think is probably common for a lot of trainee psychologists. But instead of taking that for granted, thinking about why that was there and thinking about what affect that had on me so, it did help... it helps you think about why it’s there, and it, and just letting it make sense was helpful... (Jane)

Hannah and Donna explain how through PT there is a realisation that actually most trainees do experience their own emotional struggles:

Through therapy I learnt that about myself and realised oh ok this is not how everyone is (Hannah)

I think that it helped me, probably because she is a psychologist as well, but it helped me to realise that actually everyone is going to have problems sometimes and actually that’s alright (Donna)

Eve suggested that through experience within PT that she has learnt to acknowledge and come to see her past and her struggles as something much more positive:

... Its ok, everyone’s a bit messed up.... At least I know! And I’m connected to it you know. I wouldn’t go as far to say a badge of pride, but it’s definitely a bit more at the surface and a bit freer with being open about that... (Eve)

It seems that through reflecting on these issues, and having a space to think about one's own emotions and emotionality, that participants are more able to move to a place of accepting their emotional struggles.

#### *4.5.3.3. Being okay with not being okay.*

It is my understanding that as participants reflected on their own wellbeing and perceived professional expectations of Trainee CPs within their PT, that they were able to adopt a view that feeling emotional distress is acceptable. Bryony described how this facilitates her feeling more aware of what her clients may be going through:

... and actually that it's ok to not be ok sometimes and to reflect on that... knowing that it, yeah it's ok to have your own difficulties and actually that probably makes you a bit more aware of what people are going through. I guess trying to pretend that you haven't got any difficulties makes you a little bit less human... (Bryony)

It seems that for many, feeling more accepting of emotional struggles, may allow some participants to be able to begin to ask for help.

I'm not aware of a particular conversation or anything that happened in therapy but I think that being able to reach out and actually say that [I was struggling] allowed me to actually seek support... (Lauren)

Sally describes wearing a mask, prior to exploring this within PT. This seemed to me to portray the idea common to participants that they needed to hide more vulnerable aspects of themselves within the professional roles as a trainee:

Because I am aware of how difficult I find it to say I'm struggling I think that would make me do something about it now... Whereas before, before if I didn't have it [PT] I think I would be with that mask on, like, no everything's fine and I don't think I would have been able to do this course. I mean I probably would have got through this year but I don't know if I could do the whole course pretending everything is fine all of the time and it would have slipped and that probably would have been quite catastrophic for me. So I think it's quite important that I have learnt or started to learn to look after myself and show vulnerability... (Sally).

I have understood that though their experiences of reflecting within PT on perceived professional and personal discourses around what it means to be a trainee CP, participants worked through a process of understanding the pressure that they may place on themselves in their professional role, feeling that they need to be free from emotional struggles (being okay). Reflecting on this seemed to allow for participants to understand this differently and to move to a place of feeling more accepting of their struggles, which for some participants meant they were better able to seek support and help at work.

It seemed that participants considered their professional identity within PT, perhaps as they struggled to negotiate feeling distressed with the pressure and expectations that they felt came with being a trainee CP. It seems that through reflecting on professional identity that participants came to learn about their professional selves differently. This is further impacted by participant’s experiences of being a client, which will now be discussed.

#### 4.5.4 Being a client: “Truly understanding what it’s like”

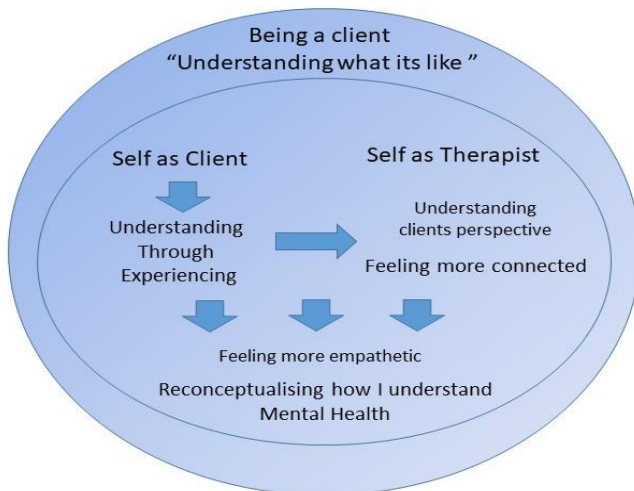


Figure 5: Concept: Learning about me being a client

This concept describes my understanding of participants’ experiences of being a client, which subsequently they apply to their work with clients. This concept is made up of one category; ‘*Understanding through experiencing*’, which described participants learning through their own experiences in PT. There are four related sub-categories; ‘*Understanding clients perspective*’ and ‘*Feeling more connected*’, which feed into the sub-categories ‘*Feeling more*

*empathetic*’ and *‘Reconceptualising how I view mental health’*. It seemed that participants worked through a parallel process in which personal learning about themselves, their emotions and what it feels like to be in the position of a client is applied to their own professional practice. The process of learning about self as a client seemed to be prompted by participants reflecting and noticing the experience of being a client, the process of learning derived from the experiences of being a client was highly valued by participants.

Something I noticed was my experience of being a client... (Jane)

Really truly understand actually what it is like to be on the other side of it (Laura)

I think there is seeing it in action, seeing it demonstrated and then also recognising what it is like to be that client... (Lauren)

#### *4.5.4.1 Understanding by experiencing*

Through being a client, participants appeared to develop an understanding of their own emotional wellbeing and seemed to reflect upon and better understand their own clients. I have understood that participants are better able to understand their own clients through feeling what it is like to be a client themselves, something which many participants explained couldn’t have been understood without having experienced it. This is demonstrated in how Donna explained having a new understanding of feeling what it may be like for clients to be in therapy through her own experiences of being a client:

I think I’ve realised how hard it is to be in that position of asking for help and even the practicalities of it... So stuff like that I think I would never have realised without having done it. Someone could have told me but I wouldn’t have really taken it on board. (Donna)

Sally talks of understanding what it is like to be a client though really feeling what it is like:

I’m kind of like, Yeah God, I understand that now. I had a real taster, kind of, I sort of you know, knew that it was scary for people but I really felt it. (Sally)

It seemed that participants learnt through lived experiences, which connected them to how certain therapeutic techniques and processes felt. Bryony describes this:

But actually to have that experience myself, and to feel actually that didn't make me feel bad... it made me feel that she was connecting with me in some way. I think that was, useful."

Laura talks of how without having the experience of being in the position of the client that it would be more difficult to truly understand what it is like:

And just little things I guess... that I valued and things that I didn't... I'd probably never really think about the small things. I think it's the same for any sort of life experience, until you've had a car crash you can't necessarily appreciate all the things that go along with a car crash. The little things you don't think about... (Laura)

Through having an experience of feeling and experiencing what it is like to be a client participants talk of better understanding their client's perspective through applying aspects of their own experiences to understanding clients.

#### *4.5.4.2 Better understanding clients' perspectives.*

I have understood that as participants have their own experience of being a client, they become able to better understand their own client's perspectives. Amy reflects on how nervous she was in her own PT and of applying this understanding to her own clients:

I mean yeah how nervous I was before going, and what I was going to say, and just how nervous I was, and I guess how long it took me to open up.... when people just come and they open up in the assessment I just think wow, you've done really well because it took me so long to just open up (Amy)

Jane talks of better understanding her own client's experiences, though comparing those to her own:

Something I noticed was my experience of being a client... and what a limited picture of what I was experiencing I could put across to my therapist... and so it helped me think about



maybe clients being in that position and not feeling maybe able to give every, to put across everything that they want to... I got a better understanding of their experience, erm, based on the disjointed, comparison to my kind of expressions of what I'm feeling compared to what I'm really feeling. (Jane)

I have understood that through having a lived experience of being a client, and feeling what it's like, that participants felt more connected to their own clients through having shared or similar emotional experiences.

#### *4.5.4.3 Feeling connected: "Bulldozing the wall down"*

Many participants spoke of how their experiences in PT have allowed them to feel more connected to their own clients. I have understood that this happens through participants being more connected to their own emotional vulnerabilities and subsequently feeling more able to appreciate their client's emotionality. Jane talks of coming to the realisation that perhaps some of her experiences are not so dissimilar to the clients she works with, facilitating a better connection:

Thinking that I am perfectly securely attached and all of those things, maybe I'm not and maybe they're not and maybe there are elements of similarity between our experiences... I guess thinking about myself and clients, as having had more shared experiences, albeit different... I believe that I've, I now recognise that I've got more in common with my clients than I did before (Jane)

Laura talks of coming to a realisation through being a client, that there are core difficulties that everyone has, helping her to feel more connected with clients:

I think in terms of PT I guess the core difficulties I was having yeah I definitely see those core difficulties in lots of clients so it kind of makes you kind of feel united that actually everything that I go through is something that other people, my clients will be going through. (Laura)

It seems that through feeling more connected with clients that participants felt better able to empathise.

#### *4.5.4.4 Being a client: Feeling more empathetic*

It seemed that participants felt better able to empathise with their own clients, through feeling more connected:

“ I think I’m much much more empathetic as a result which really helps, erm, and I’m more open to feeling my pain in response to their experiences...” (Jane)

“I think its really brought back the empathy, and you just get used to it like, I’m just doing this all the time and it really sort of hit home what it means.” (Sally)

“I guess just having that bit more empathy of what it might be like for your clients...” (Lauren)

“Engaging with empathy rather than just saying we’re being empathetic...” (Brian)

I think you’re kind of understanding your empathy is just deeper somehow... I guess it maybe just comes a bit more automatic and maybe there’s kind of a deeper connection perhaps if you can really truly understand actually what it is like... (Laura)

Through experiencing and learning about the self by being a client I have understood that many participants begin to reconceptualise how they understand mental health.

#### *4.5.4.5 Reconceptualising conceptions of mental health*

It seems that participants’ came to reconceptualise their experiences of mental health through the described experiences related to being a client. This happens in a more explicit way for some, but is implicitly discussed by participants throughout. Hannah talks of this broadening her perspective of mental health:

We’re just trying to work it out together, and let them sort of, I don’t really know how to describe it, but it definitely feels less pathologizing. It’s not like you are the person with the problem and I am here to fix ...it’s more like well, we’ll work it out together, and we all could experience this... (Hannah)

Similarly Sally described shifting in her understanding of mental health:

and more just mmmm less like there is a difference between us really, also I think the things I have learnt through therapy I sort of feel like I understand more that everyone is sort of vulnerable to mental health problems (Sally)

Laura talks about her perception of mental health broadening:

And I guess you know partly through my therapy there was the kind of the realisation and acceptance that it's not about being mentally ill or not being mentally ill... It's about relationships; it's about identity and it's about anger and it's about depression and it's about love and these core core things that are just human and it's just about humanness... when it comes down to distress I think we are all distressed at the end of the day. (Laura)

I have understood that as participants experienced being a client that they came to reconceptualise how they thought about mental health, and mental health difficulties become more normalised.

It seems that through the experience of being a client, and of learning what that may feel like, that participants learnt about themselves personally, and were able to apply these experiences to their own professional practice as they better understood their clients perspective and begin to shift how they conceptualise mental health. I have understood that through learning about themselves personally, professionally and through being a client that participants develop in their sense of their professional and personal identity, and are more able to bridge these aspects of themselves, as well as to model what has been useful in the context of their own PT.

#### **4.5.5 Personal and professional identity integration**

I have understood that a key development of the described experiences, is the integration of personal aspects of the self into the professional identity (*Personal and professional identity integration*), or as Jane described “creating a hybrid”. The process involved participants being more able to integrate personal attributes of themselves into their professional practice and identity, as Laura described:

It's not a job I don't think where you can fully separate yourself from who you are as a clinical psychologist and who you are as a person... you have to take your personality and a bit of yourself in and I think that's a part of building relationships with people... (Laura)

Laura goes on to explain how experience within PT enabled her to bring more of herself into her professional role:

I feel much more I guess from my therapy I feel like I'm more kind of accepting of myself and yeah and I guess in that way the more you kind of feel comfortable with yourself and accept yourself, the more likely you are to take that into client sessions.

It seems that as participants reflect upon their professional context, and have experiences within PT that help them to move away from an idea that they need to be emotionally well all of the time, that they begin to incorporate aspects of their personal self into their professional identity. This process seems to be further impacted by participants growing understanding of themselves, and who they are, as well as through the powerful learning experience of feeling what it is like and being more connected with their clients. Donna described this:

... I guess it's about that kind of genuine relationship you're building with them and not building a relationship with them based on a completely different robot person I take to work compared to who I am in person really. (Donna)

Whilst Jane reflected on shifting from having a very set professional role, separate to who she was within her personal life to these aspects of herself being more entwined:

I feel, more like, its two humans meeting rather than a client and a therapist in those really set roles. (Jane)

Sally talked of the freedom that feeling more fluid in her professional identity allowed her and how she felt this impacted on client work:

It felt really nice to kind of not have to be oh I'm the professional and I know the answers and I'm always okay, and like, it's both kind of helpful cos it's not true and it sort of empowers like the client but then for me as well it kind of takes the pressure off cos it's like oh god I don't have to be that thing, because we are all the same, and I'm not this super human that has to be fine... (Sally)

For many this integration lead them to feel more effective within their clinical work, and as trainees, as Hannah described:

I think if we just took the teaching and that was all the learning we did in relation to our job I don't think we'd be very effective if we didn't then take the personal life learning that we do as people and were willing to apply that to work, I think. (Hannah)

It seemed that experiences in PT lead to more of an integration between personal and professional aspects of the self, and for many this allowed them to feel more competent. I have understood that another core development for participants through experiences in PT is in them modelling aspects of their own PT.

#### **4.5.6 Modelling: “I heard his words through mine”**

I have understood that through the development of their experiences in PT that participants begin to model aspect of their own PT that has been helpful. This category has two related subcategories; *Modelling Content* and *Modelling Process*. This process seems to happen gradually as participants spend more time in the position of the client and come to understand what they value. As described by Laura:

... noticing things that I valued and things that I didn't. But if I never sat in that waiting room then as a therapist I probably would have, I'd probably never really think about the small things.

It seemed that as participants began to experience aspects of their own therapy which were meaningful, that they came to model these. The process seems to happen in a number of ways, one of which involved participants directly replicating aspects of their own PT (*Modelling Content*):

I kind of heard his words through my words, it's okay just let it out, don't hold it in, it's okay, it's about us accessing our emotions and so yeah I definitely heard him through me there.

(Lauren)

So I try, I do that with all clients now. I don't really know what I did before I think I just did it in a less in a less sophisticated way. (Sally)

I have found myself saying things before and being like, oh my god, my therapist said that to me, maybe I shouldn't have said that. Actually it tends to go down quite well. (Jessica)

For other participants modelling involved creating the same sort of space, or conditions that they have seen within their own PT (*Modelling Process*) As Jane and Eve described:

Whereas I had an idea about how to set up a therapy room before and what I was comfortable with I guess I thought about it more from the client's perspective... I've made more of an effort to kind of simplify therapy rooms... (Jane)

Eve talked of learning to slow down, to be less formal and of how she understood the value of this from her own experiences in PT:

I feel like it's not me interviewing... I think there's a slight shift in my style where I try, not that I've been consciously aware but it feels more like a conversation. And also picking up more on signals and thinking I can, you know, non-verbal's, things like that, that I might be able to relate to a bit more, picking up from a client that there might be something else going on. Not being so caught up in what I want, my intentions... (Eve)

I have understood that as participants learn about themselves personally and professionally, and through being a client that they begin to notice what they value and subsequently seek to replicate this within their own clinical practice.

#### **4.6 Summary**

Although participant's experiences within PT were varied, it seemed that important aspects common to these were in the decision making process to use PT, and the way in which they learnt about themselves personal, professionally and through being a client. Results will now be summarised and discussed in relation to the research literature.

## CHAPTER 5: DISCUSSION

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### 5.1 Overview

This study sought to explore and develop a preliminary, yet substantive, understanding of the mechanisms through which twelve Trainee CPs experienced PT whilst training and how it influenced their development. The model constructed from the data is best understood as a model representing trainee CPs experiences of psychodynamic psychotherapy, as all participants were engaged with or had used this modality of PT. This chapter will re-orientate the reader to the aims of the study, and in doing so provide a summary of the key findings that have been constructed via the analysis. The findings will be situated within the existing literature, and understood in terms of relevant psychological theory. Reflections on the methodology and discussions of the relative strengths and limitations will then be presented. This is followed by a discussion of the clinical relevance and potential significance of the research, alongside recommendations for future research. Finally, a summary of my personal reflection on the research process is presented.

### 5.2 Returning to the Research Question

The study aimed to answer the following research question:

- How do Trainee CPs experience their own PT, and how do experiences relate to their development in training?

A summary of the key findings in relation to the research question will now be discussed.

### 5.3 Summary of Findings

Two models of processes relevant to experiences and development in PT were constructed from the data. Model 1 is a decision making model, and represents how I have understood participants made the decision to use PT (**4.2.1 Figure 1**). It is made up of three core categories, and a number of associated sub-categories. Model 2 (**4.2.1 Figure 2**) represents my understanding of participants' experiences within PT, and is a model of learning about the self. It is made up of four core categories and a number of related categories and subcategories. It is beyond the scope of this thesis to conceptualise each of the subcategories. As such, these will be summarised and synthesised into an understanding of the core categories.

### **5.3.1 Making the decision.**

I have understood that key to participants' experiences of their own PT, was the decision making process that they worked through in electing to use PT whilst training. In making the decision to use PT, participants appeared to move through a process of contemplating (4.3.2), to committing (4.4.5) to seeking out and attending PT. The process is mediated by a trigger that I have understood as experiencing or anticipating distress (4.4.4).

This movement from contemplation to commitment could be understood in terms of Prochaska and DiClemente's (1983) model of change. It suggests that change occurs when the stages of pre-contemplation, contemplation, preparation, action, and maintenance have been moved through. The pre-contemplation stage marks a time when change is not being considered. In the context of this research, many participants talked about not really thinking about beginning PT prior to the start of training, and therefore I have considered this as a pre-contemplative stage in the decision making process. The contemplation stage, involves a time when change is seriously considered. This is evident in the current study in participants weighing up the costs and benefits within contemplating the decision to use PT. The preparation stage of the model involves preparing for change. In the current research, this is illustrated by participants beginning to think further, and make plans to organise PT. The subsequent stages involve moving into action, a period of making the change, followed by a maintenance stage. In this study these stages are demonstrated in participants beginning PT, and in committing to it, even at times when it felt difficult (4.4.5).

It is important to note that this model of change has been widely criticised as limited evidence exists to demonstrate that the effectiveness of stage based interventions in predicting a range of behaviours (Riemsma et al, 2003). It is also arguably considered most relevant when considering addiction related behaviours (DiClemente, Schlundt, and Gemmell, 2004). In the context of this study its usefulness relates to understanding change, or decisions as involving cyclical stages, which seem to relate to behaviour.

I have understood that in making decisions about PT, participants anticipated or experienced distress which acted as a trigger to embarking upon PT. The trigger appeared



to move participants from the contemplating to committing phase. Lemerise and Arsenio (2000) have evaluated the role of emotions in decision-making. They have suggested that, at a cognitive level, choices and the consequences of choices are considered, but that emotional factors impact upon cognitive processes and behaviour (Lemerise and Arsenio, 2000). The authors suggest that feelings about decisions and expectations about likely emotional outcomes of decisions may assist people in prioritising between differing choices. In line with this research it may be that the emotions related to feeling or anticipating distress may be key in decision-making processes around seeking out and accessing PT. It may be that the perception of the benefits of PT may change once participants experience emotions related to anticipated or actual distress.

The current research indicated that the decision to use PT was influenced by participants experiencing distress related to aspects of training, to personal events, or as preparation to deal with the anticipated stress of the course (4.4.4.1). Cushway's (1992) survey data of trainee CPs experience of distress whilst training suggests that 59% of a sample of trainee CPs experienced high levels of distress, and that 75% reported feeling moderately or very distressed as a consequence of training. Results indicated course structure and organization, amounted for the highest amount of variance in stress ratings, the process of training, and professional self-doubt was also considered as a contributing factor. A further review of trainee therapists and counselors reported that high levels of stress were common amongst the population, with results indicating that ambiguity in the professional role was a major contributor to trainee's stress levels (Skovholt & Ronnestad, 2003). Wilson et al. (2015) Narrative Analysis of CPs' accounts of experiences in PT, suggested that participants had shared narratives around the impact of training, influencing the decision to use PT to cope with the stress and pressure. Similarly to Wilson et al. (2015) the current study indicated that many participants reported some resolution to stressors or difficulties as a result of PT, perhaps indicating that PT may be supportive to trainees experiencing distress whilst training. These results highlight the impact that training may have on some Trainee CPs, and implies a need for courses to consider both formal and informal support mechanisms, of which PT may be one.

Results of the current study indicated that perceptions of how courses viewed the use of PT impacted on the decision making process. It seemed that for participants at courses in which

PT was perceived to be discouraged, the decision to access PT was more difficult (4.3.4.1). For participants at courses where PT was perceived as being discouraged, there was a sense of shame and worry related to talking about experiences of accessing PT. Similarly, Digiuni et al. (2008) found that appraisals as to the benefits of seeking therapy may be impacted by how therapy is believed to be perceived by others (faculty members and the wider society). Theories of Reasoned Action (Ajzen and Fishbein, 1980) are helpful in understanding this finding. This theory holds that the primary determinant of behaviour is intention. Intentions are believed to be derived from a person's attitudes toward the behaviour and their perceptions of the social norms regarding the behaviour. Decisions to access PT are then understandably more difficult for participants whose perception is that accessing PT is not socially normative within the context of training.

The findings of the current study are the first to detail the process by which decisions might be made to use PT whilst training. Although the results are not generalisable to the entire population of trainee CPs, results can be considered to have some relevance, particularly given their convergence with prior research and theories of decision-making. Given that the decision to use PT involves the weighing up of benefits and costs within contemplating its use, it might be helpful for training courses to provide some assistance to trainee CPs in understanding these at the outset of training.

### **5.3.2 Experiences within PT and the relation to development.**

The core concept of the constructed model represents what I have understood to be key to participants' experiences in PT, and describes a process of learning about the self: 'Learning about me'. Participants seem to develop and learn about themselves across the three conceptual domains: Learning about me: personally (4.5.2), Learning about me: professionally (4.5.3), and Learning about me: being a client (4.5.4). It seems that at the outset of PT, personal and professional aspects of the self are more separate. Throughout PT, these aspects become more interrelated, and development in one area will impact upon development and learning in the other.

I have understood that the process of learning and development happens via the continuous process of participants taking a dilemma related to one of these domains to PT, reflecting upon this, and through reflecting on this, having a way of understanding these aspects of themselves

differently (4.4). Each of the core conceptual categories involves different mechanisms that lead to the development of greater self-awareness, feeling more accepting of emotional struggles, and better understanding clients' perspectives and experiences. These experiences and developments seem to result in participants being able to model positive aspects of their own PT, and to be more integrated in their personal and professional identity, both of which could be considered aspects of professional development.

I have understood that through experiences within PT participants develop both personally and professionally. This is in line with the research previously reviewed on trainee CPs (Moller et al., 2009; Nel et al., 2012; Wilson et al., 2015) and Counselling Psychologists (Grimmer et al., 2001; Kumari, 2011; Williams et al., 1999), in which participants were considered to have developed personally and professionally via experiences in PT.

Studies evaluating the use of PT with therapists of differing professional backgrounds, also report the relation between experiences of PT and PPD (Wigg et al., 2011). Sheikh, Milne and MacGregor (2007) propose a theoretical understanding of the process of PPD in CP training, drawing on models of experiential learning and reflective practice, both of which they argue are key to PPD within training. Experiential Learning Theory (ELT) suggests that learning occurs via a process in which experiences are transformed into knowledge (Kolb, 1984). There are four modes of grasping and transforming experiences said to contribute to knowledge (Kolb, 1984). The two dialectically related modes of grasping experience are described as Concrete Experience (having an experience) and Abstract Conceptualisation (thinking about the experience/why did this happen), which transform experiences via Reflective Observation (feeling/what did I experience) and Active Experimentation (what will I do/action) (Kolb, 1984; Sheikh et al., 2007). The immediate or concrete experiences form the basis for observations and reflections which are then assimilated into abstract concepts which inform action.

The results of the current study could be understood within the context of this theory of learning. It seems that participants use PT as a space to learn about themselves via the continual process of taking dilemmas (concrete experiences) to PT, where they think about them (Abstract Conceptualisation), reflecting on these and moving to understanding them differently (Reflective Observation). For some participants this learning translates into action

(Active Experimentation). Within this study, the active experimentation stage is perhaps better understood as participants experiencing a sense of choice about what action to take based on the learning which has occurred (4.5.2.3). It seems that ELT theory provides a frame in which to understand the development of learning for participants within this study.

Models of the development of reflective practice are also relevant in understanding the results. Lavender's (2003) model outlines four separate but connected methods of reflective practice. Three of these methods: reflection on action (reflecting on action which has already passed), reflecting on impact on others (becoming aware of how one's actions or emotions impact upon others), and reflecting on self (involving development of self-awareness and self-understanding), appear relevant to the experiences of participants within this study, and reflect the ways in which trainees are suggested to develop reflective skills. This is particularly relevant in how I have understood participants' personal learning about the self (4.5.2), which impacts upon professional learning and practice. The two models described above fit with how I have understood participants' experiences and development in the current study. This suggests that for participants in this study, PT may be a method of experiential learning about the self, which impacts upon clinical practice. The various aspects of the model will now be discussed in more detail.

### **5.2.3 Learning about me personally: Understanding who I am**

In line with previous research, it seems that central to participants' experiences in PT is gaining more of an understanding of who they are (Grimmer et al., 2001; Kumari, 2011; Macran et al., 1998; Moller et al., 2009; Wigg et al., 2011; Wilson et al., 2015). Within this study I have understood that learning about the self occurs via a process in which participants reflect upon themselves in relation to others, and via reflecting upon and understanding their actions. The outcome of this seems to be that participants develop in self-awareness, which I have understood allows participants to be more reflexive about themselves in relation to their clinical work, (4.5.2.3). Similarly, Grimmer et al. (2001) suggested that PT supported trainee Counselling Psychologists in being more self-aware, which in turn impacted on how participants understood relationships with clients. In Kumari's (2011) research, a constructed super-ordinate theme was 'Personal Development', in which participants were understood to develop a deeper understanding of themselves, which was believed to be relevant to practice.

The developments described above could also be understood and described as personal development. In relation to CPs training, Gillmer et al. (2003) defined personal development as trainees developing in reflective capabilities regarding the work-self interface. They suggested that this process may result in trainees developing in self-awareness and resilience. Similarly, personal development has been described as the process of increasing self-awareness and self-knowledge (Youngson et al., 2009). Understanding the self in relation to others and developing one's self-identity is noted by Hughes (2009) as a central component of personal development. In relation to the research question, participants' experiences of reflecting upon oneself, may lead to developments in self-awareness relevant to personal and professional practice. Given the convergence of the current results with prior research, it could be suggested that PT may be a method of developing personally during CP training. This is of relevance as personal development is central to CPs practice and professional competencies (BPS, 2015; Youngson et al., 2009).

#### **4.2.4 Learning about me professionally: understanding my professional role**

I have understood that as well as personal learning, key to participants' experience in PT is learning about themselves as a professional. It seems that participants reflect on their professional context within PT, coming to understand that this context may perpetuate expectations of 'being superhuman'. It seems that the perception of what it means to be a trainee may feel at odds with what feels achievable (4.5.3.1). Participants reflect upon a professional context, which they feel pays little attention to the potential that trainees may experience their own emotional distress, and a lack of emphasis on the person of the professional (4.5.3.1). It may be that this results in a separation between personal and professional identity, with professional identity conceptualised as being free from emotional struggle, at odds perhaps with personal aspects of the self. These ideas subsequently led participants to a worry at the outset of PT about being judged personally and professionally for feeling distressed and for using PT (4.5.3.2). This is in line with research by Wilson (2015), in which a main identified narrative for the participants who took part was the stigma of accessing PT.

In the current study the ways in which participants discussed their professional context fits with how existing research has understood this. Aina (2015) explored Trainee CPs experiences of psychological distress and found that experiences of personal distress are challenging to

discuss within training, relating this to the culture of the profession. Walsh and Cormack (1994) looked at barriers to help-seeking amongst distressed CPs and found that they considered the idea of receiving support threatening, threat compromised three elements: professional threat, fears about being a client, and worries about having to gatekeep distress. Results indicated that there were also concerns about being compared to colleagues who were perceived to be ‘perfect copers’ Davidson and Patel (2009) have discussed a professional rhetoric, that in order to practice clinically, CPs should be immune to psychological difficulties, which many participants within this study reflected on (4.5.3.2). Others have argued that Clinical Psychology has developed historically as a profession in which there is an impression of invulnerability, and that this may result in extreme expectations for self-efficacy that may lead to personal difficulties being associated with clinical incompetence (Skorina, 1982). The results of the current study highlights how the professional context of Clinical Psychology may impact on participant’s identity, something which is reflected upon within PT.

Role Identity (McCall & Simmons, 1978) and Social Identity Theories (Tajfel & Turner, 1979) both add to an understanding of the social basis of the self-concept and on the nature of normative behaviour (Hogg, Terry, & White, 1995). These theories go some way in explaining how the professional context of Clinical Psychology may impact on self-identity and subsequently the behaviour of trainee CPs. Role Identity Theory describes the interactions between internal and external role expectations. Individuals are understood to construct a role identity based on social and personal identity. Charlemagne-Odle, Harmon and Maltby (2014) have applied this theory to understanding role identity within Clinical Psychology. They suggest that CPs’ social role (as a role model of mental health) will be reinforced by society, but that individuals may also self-evaluate their professional efficacy based upon idealised self and personal expectations, which may be high due to the nature of being in a helping profession (Charlemagne-Odle et al, 2014). Further, this may interact with professional expectations of ‘professional perfection’. This theory may well help in understanding participants’ understanding of their professional role and the associated expectations, in addition to helping to understand the finding that participants may have feared judgement for accessing PT.

Social Identity Theory (Tajfel et al., 1979) may also help in explaining participants' fears around judgement when accessing PT. The theory suggests that the social categories (in-groups) a person may fall into (Trainee CP), as well as the ones in which they feel they belong, impact upon self-concept. The self is understood in relation to the characteristics of the differing social categories to which it belongs. Social categories are represented as a social identity, in which there will be expectations of particular attributes describing how one should think, act and feel. So, as a Trainee CP accessing PT, participants could be considered to be acting, thinking and feeling differently to others within this social category, which would likely impact on one's self-concept. These ideas relate to the findings of the current study, in that participants within this study initially felt judged for experiencing distress which leads to them accessing PT, which they may have understood as not normative. This idea can be seen in participants wondering about whether a psychologist should have difficulties (4.5.3.2). It seems however, that participants use PT as a space to reflect on perceived professional discourses which alongside other experiences described, may allow them to shift in how they think about being distressed (4.5.3.3).

I have understood that reflecting on professional context, and becoming more comfortable with experiences of distress facilitated shifts in how participants understood their professional role, moving away from previously conceived notions of the need to be 'superhuman'. Similarly Wilson (2015) suggested that participants found that PT impacted on professional identity. Grimmer et al. (2001) suggested that for participants in their study, PT provided a space which supported the emerging professional.

#### **4.2.5 Learning about me as a client: "Truly understanding what it's like"**

Within the current study, I have understood that key to participants' experiences in PT is key to how they learn about being a client. It seems that as participants learn about being a client, they are able to apply these experiences to how they understand their own clients too (4.5.4). It is worth noting that this aspect of participants' experiences was often described as extremely meaningful; many participants spoke of this having a profound impact upon how they think about mental health and how they practice. Participants seem to begin to understand themselves differently by being in the position of a client, and learning what this may feel like. Learning via this process could be well understood using ELT, in that participants have a concrete experience of being a client, in which they learn through both the experience and the

emotions connected with the experience, which are reflected on within PT. These experiences are then related to their own clinical practice.

These findings fit with existing research literature on Counselling Psychologists' experiences in PT. Grimmer et al. (2001) investigated Counselling Psychologists' experiences of PT and identified the core category 'reflection on being in the role of the client'. They described how participants could better understand the therapy process for clients by reflecting upon their own experiences, and that they were likely to replicate positive experiences and avoid replicating negative experiences. Similarly, Kumari (2011) constructed a super-ordinate theme of 'Experiential Learning'. Within this study, it was understood that PT was considered a valuable opportunity to gain specific skills and to try to use these in clinical work. These included skills in understanding and developing therapeutic relationships, learning first-hand about techniques, and knowing what it feels like to be the client. In their exploration of trainee therapists' experience of PT, Moller et al. (2009) constructed the theme: PT helps me to be a better practitioner. The subthemes included participants' descriptions of experiential learning and development via being in the role of client, which led to modelling aspects of their own PT. Learning from being in the role of the client has been found in the wider literature on a range of therapists' experiences in PT, and is often described as a socialisation experience into the role of being a therapist (Macran et al., 1998; Wigg et al., 2011). In line with the discussed research it may be that experiential learning through being in the role of the client is key to the experience of PT for trainee CPs, assisting in their development of skills relevant to clinical practice.

In the current study I have understood that via the experience of being a client, participants feel more connected with their clients (4.5.4.3) via shared emotional experiences. This facilitates what I have understood as participants developing in terms of how able they are to empathise with their own clients (4.7.3.4). This finding is supported by much of the literature on trainee and qualified therapists' experiences in PT (Grimmer et al., 2001; Kumari, 2011; Macran et al., 1998; Moller et al., 2009; Wigg et al., 2011; Wilson et al., 2015).

Empathy has been described as a process of feeling "as if one were the other person" (Rogers, 1959, p.210). It is perhaps unsurprising then that participants in this study felt better able to empathise with clients, through having shared experiences, feeling more connected, and having



an appreciation of being a client. Empathy has long been considered an essential ingredient in the success of psychological therapy (Duan et al., 1996). It is considered one of the common factors that have been demonstrated to correlate with client outcomes (Lambert & Barley, 2001). Research has demonstrated the impact that empathy has on therapeutic change in a number of studies (see Duan et al., 1996, for a review). It may be then, that participants' perception of being better able to empathise with clients may be an important development in terms of their professional skills. It is important to note however that participants' description of greater degrees of empathy within this study are self-reported. Research has demonstrated that it is only client's perceptions of empathy, which impact on client related outcomes within therapy (Gurman, 1977; Orlinsky & Howard, 1986). It can however be suggested that within this study, participants experiences in PT leads them to perceive and feel that they have greater levels of empathy, perhaps contributing to them feeling as though they had developed as better practitioners.

I have understood that through an accumulation of the discussed experiences that participants within this study came to model aspects of their own PT perceived as useful. Additionally they seem to develop both in terms of their personal and professional identity which I have understood contributes to these two aspects of identity becoming more integrated.

#### **4.2.6 Developments: Modelling and Personal and professional identity integration**

In line with prior research (Grimmer et al, 2001; Kumari, 2011; Moller et al, 2009; Wilson et al 2015) it seems that through the described experiences within PT that participants begin to model aspects of their own PT, which for some allows them to feel more competent. This could be understood as a process of social learning. Social Learning Theory (Bandura, 1978) maintains that behaviour can be shaped by expectancies and incentives (Rosenstock, Strecher, & Becker, 1988). Expectancies may be related to beliefs about how events are connected (contingencies), expectancies about the consequences of performing the actions, or ideas about how actions may influence outcomes (Rosenstock et al, 1988). Key to the theory is the notion of self-efficacy, the idea that one will only perform the learnt behaviour if they believe that they can and that it will be connected with the desired outcome (Rosenstock et al, 1988). Incentives refer to the perceived value of the desired outcome. This is relevant to how I have understood participants' model aspect of their own PT they have perceived to be beneficial.

It may be that as participants come to learn the actions their therapists perform which lead to positive outcomes within their own PT that they learn that these are contingencies leading to positive outcomes, which they may then want to replicate within the context of the therapy they provide. Participants reported that modelling things that they had found useful could lead to them feeling more sophisticated (as Sally described, 4.5.6). Perhaps then incentives for modelling positive aspects of their own PT may be gaining the potentially desired outcome of feeling more competent. Within the current study modelling appeared to be a developmental outcome of PT, perhaps then in line with social learning participants need to move to a place of feeling efficacious in modelling their own therapist's actions before they feel able to perform these themselves. It seems that for participants within this study that PT provided an environment for social learning about being a therapist, which for many have led to feelings of greater competence.

I have understood that another key aspect of participant's development within PT is the assimilation of aspects of their personal self into their professional identity. Which I have understood allows them to feel more genuine within their professional role, as Laura and Jane described (4.5.5). I have understood that this process is impacted by the personal, and professional learning that participants experiences within PT, and is impacted by their experience of feeling what it is like to be a client. Within the literature review presented by Wigg et al. (2011) on therapists use of PT, common themes identified were grouped into subordinate themes of personal and professional reflections. Professional reflections incorporated themes of constructing a professional self via connecting the personal with the professional self. This links with the findings of the current study, in that participants seem to integrate personal and professional aspects of the self into a more coherent self-concept.

### **5.2.7 Summary**

In answering the research question, I have understood that participants' experiences in PT involve personal and professional learning about the self, and about the experience of being a client. This appears to impact on identity and the outlined aspects of clinical practice. The process in which this happens can be understood in terms of ELT.

A novel finding within the current study is that making the decision to use PT is a complex process, and may be influenced by how the trainee, institution and the profession talk or do not talk about PT. It is also relevant that many participants reflected on professional contexts which perpetuated discourses around what it means to be distressed and how this then related to experiences in PT. These findings potentially contribute to an understanding of Trainee CPs help-seeking, which may well be impacted by the professional discourses described within this and other studies. Both of these factors may be helpful in thinking about how Clinical Psychology as a profession considers both experiences of distress, and PT. This will be discussed further in considering the implications of the current research.

The finding that key to participants' experiences is learning about the self - personally, professionally, and by being a client, is in line with much of the current literature on trainee and qualified therapists' experiences of PT (Grimmer et al., 2001; Kumari, 2011; Macran et al., 1998; Moller et al., 2009; Wigg et al., 2011; Wilson et al., 2015). It therefore provides support within this population that PT may be a mechanism for reflective practice and PPD within the professional training of CP. This study began with an exploration of the context of CPs training in the UK, introducing the idea of the reflective practitioner model. As discussed, within this and other relevant studies, PT may contribute to the development of reflective skills and PPD relevant to this model, supporting the notion that PT may be one method of assisting Trainee CPs in meeting the competencies of the reflective-scientist-practitioner model of training.

## **5.4 Methodological Reflections**

### **5.4.1 Strengths & Limitations**

The current study is an innovative exploration of the processes within which trainee CPs experience PT whilst training, in which methodological rigour has been attempted throughout (see section 7.4, Appendix U). As discussed, there is a limited amount of published research within this population, and this study adds to the research exploring this phenomenon. The choice of the GT method complements the existing literature in that it provides a tentative model for understanding experiences and development, grounded in the data. This understanding of the mechanisms via which participants experience and develop within PT may now be tested using other research methodologies, in order to substantiate the findings. It was not the aim for findings of this study to be generalisable, however it is possible to learn

from them and they can contribute to understanding the possible benefits and impact of PT within the context of training CPs. Given their convergence with research assessing PT for other training professionals, the results may provide useful information in understanding PT as a method for reflective practice and PPD. They also can contribute towards providing some guidelines to training institutions as to how to talk about PT and distress in order to support trainees.

It is however important to note the limitation of this research. As discussed, many participants initially came forward to participate in the study. However, due to the recruitment strategy and the reliance on information being shared via training courses, not all courses agreed to send out recruitment emails and therefore the sample represents trainees from only six of the thirty UK courses. Given that how courses appear to talk about PT seems to impact on decision-making and experiences of PT, it may be that if a wider pool of participants across different courses had taken part, the results may have differed. All of the participants who took part were engaged with some form of psychodynamic therapy. Given that this kind of PT lends itself to self-exploration it may be that the results reflect experiences within more exploratory forms of PT. Results are therefore best understood as a model of participant's experiences and development within psychodynamic form of PT.

It is important to note that one of the participants within the study described extremely painful experiences within their PT, which were considered to impact on how they were able to engage with training. Conversely however, this participant had described struggling with training prior to beginning PT, and of this being an impetus to begin the process. Other participants did not speak in detail of negative experiences of PT, although many did describe the process as painful at times this was not central to their experiences or development, and was therefore not considered key to the described model. I have wondered if it may have been difficult for participants to talk about negative or painful experiences within their own PT, as it may be exposing or upsetting in some way, and may well have been influenced by my role as an interviewer and trainee CP. This may well have served as a limitation of the study, if indeed more negative experiences were not able to be storied. Alternatively, it may be that the participants who took part in the project may represent a group of trainee CPs who on the whole had positive experiences of PT and may not represent the whole range of different experiences that trainee CPs may have when using PT whilst training. Within the scope of this

study it was not possible to continue to sample to try and recruit people who had perhaps had more difficult experiences within their PT. This may have been useful in understanding further trainee's experiences of PT, and indeed if trainees who have more difficult experiences still perceive themselves to develop through the process in the ways outlined in the current study.

It seems that for many participants there was an understanding that PT would be a useful way of understand the self, which was considered important to the profession prior to experiences in PT. It may be then that the participants who came forward represent a sample who perceived PT to be a beneficial learning experience, both before and after the experience. The results should then be viewed with a certain amount of caution and may be understood as representing the process of experiences and development for trainees within the context of exploratory PT, for those who consider PT an important aspect of training.

The use of GT methodology within the study served as both a strength and limitation. Given more time, a wider pool of participants would have been recruited and the use of a focus group considered in order to further test the models constructed. GT methodology aims to explore processes across diverse members of a specified population (Charmaz, 2008). The sample was diverse in some ways but not in others. All participants were using psychodynamically-oriented PT, only one male participated in the study, and all participants were White-British, or White-European. This may represent the relatively small number of male trainees and trainees from differing ethnic groups within this population. However, it cannot be said that the sample was diverse, presenting a limitation.

Finally, it is important to acknowledge that my primary role is as a clinician, providing therapy within NHS contexts. As such it is important to note that I come from a place of understanding therapy as efficacious and am invested to some degree in an understanding that it impacts upon personal development. In line with my position as a social constructionist, it may be that my personal experience of PT and my role as a CP may have furnished me with a lens through which I viewed the data. I acknowledge that it is impossible to completely disentangle myself from my own experiences, and it may be that this impacted or influenced the questions that I asked and how participants were able to respond to these. I have attempted to engage with reflexivity throughout the research process, which I hope will have minimised this. Given that

I am inextricably linked with participants in the process that I am studying, I provide a detailed account at the outset of the study and in Appendix X of how I have owned my own perspective.

## **5.5 Implications**

The current study along with the reviewed literature highlight a number of areas to consider, due to their implications to the training of CPs. Primarily, the results support the notion that PT may support reflective practice and therefore the reflective practitioner model of training. Results also highlight the necessity for training institutions and the profession to consider how to support trainee CPs during their training, as it appears to be a time in which they can experience emotional distress. Results highlight the need for trainees to have up to date and relevant information on the merits of using PT whilst training and how it could support or hinder the process of training. Finally, the results of this study, alongside others highlight that trainees as well as trained CPs can feel a sense of shame for their experiences of emotional distress. This finding raises serious questions about a helping profession and how mental health is conceptualised within this. These implications will now be discussed.

The discussed literature on the use of PT by training Counselling Psychologist, in addition to the results of the current study and the reviewed literature on CPs use of PT, provide support for the notion that PT may be one method of developing personally and professionally within the training of CPs. A key mechanism by which these developments occur seems to be via the space that PT provides for a continual process of learning. Of particular importance within this study was that PT was perceived to assist participants in evolving an understanding of the self, which is key to the development of reflective skills and practice (Lavender, 2003).

Research has suggested that reflective practice is considered essential to better understanding the personal impact of clinical work, helpful in understanding and engaging with clients, important for the development of the therapeutic relationship, and helpful in understanding professional roles as clinicians (Fisher, Chew and Leow, 2015). The role of reflection has also been linked with the development of formulation skills. (Stedmon and Dallos, 2009). The importance of reflective practice to the profession is also supported by the reflective-practitioner model, now central to the profession of Clinical Psychology. Given its importance it is problematic that there is such a limit in research evaluating methods for the development of reflective skills. The current research contributes to understanding PT as one such method,

and implies that training course, as well supervisors and Trainee CPs could benefit from understanding the potential utility of PT for training reflective CPs. It is important to note however that there is little research to demonstrate the impact of reflective practice on clinical practice, outside of studies utilising self-reports (Mann, Gordon and MacLeod, 2009). A potential area of research in need of development in order to clarify if the reflective-practitioner model or if reflective practice does indeed enhance clinical practice as reported. The difficulty of defining and measuring reflective practice seems to hold back research within this area, despite its importance.

An important finding of this research was that Trainee CPs within the sample had experienced a time of feeling distressed. For many this distress was related to aspects of training, a finding supported by prior research (Cushway, 1992; Wilson et al, 2015). Importantly, participants within this study also expressed feelings of concern and fears around being judged because of their experiences of distress, despite the fact that the literature suggests that this is perhaps a common part of the training experience (Cushway, 1992). Participants within this study found PT a useful way to manage feelings of distress, however it could be argued that PT may not be either accessible or an acceptable method of support to all trainee CPs. Arguably, there should also be ways of managing or reducing trainee stress/distress from training institutions. There has been a growing body of research in methods of supporting Trainee CPs with their own experiences of distress whilst training, perhaps as an acknowledgment of the demands that come with it. Stafford-Brown and Pakenham (2012) evaluated an Acceptance and Commitment Therapy based group programme aimed at reducing stress. Findings indicated significant reductions in work-related stress, and distress. Mindfulness Based Cognitive Therapy groups, have also been demonstrated to be effective in reducing stress for first year Trainee CPs (Rimes and Wingrove, 2011). Some training programmes in the UK have links with free short-term therapy services, which can support trainees who may be struggling (Clearing House, 2017).

The results of the current study indicated that PT may be one method of coping with distress. However, the results also demonstrate that it may be useful to consider group programmes for trainees to support them with difficult feelings, of which one of the two considered above could be relevant. The current research certainly implies that it may be prudent to review what formal and informal support structures are in place to help trainees when they may be struggling, and

to utilise research to normalise experiences of stress and distress, and to consider if any additional support processes may be necessary. It could be relevant to include teaching at the outset of training in which trainees are given space to reflect on what they may consider could be difficult about training, and how difficulties could be managed if this was necessary.

Making the decision to use PT involved participants contemplating the potential costs and benefits. It could then be considered a necessity for training courses to consider the use of PT with trainees at the outset of training, as this would likely allow trainees to make informed decision about this, based on appropriate information and research, of which the current study could contribute. As discussed the potential costs or drawbacks of using PT whilst training was not something considered central to the results of the current study. Emotional costs were considered within two reviewed studies (Moller et al., 2009 and Wilson et al, 2015). However in both studies the authors suggest that participants considered that the benefits outweighed the costs. In helping trainees to consider the use of PT whilst training it would be important to draw on the current as well as reviewed research, presenting trainees with the relevant information. This could also be supported where appropriate with past trainees or teaching staff reflecting with trainees on their own experiences of using PT whilst training. Something which participants in the current study considered helpful to decision making where provided. Open conversations about the use of PT may also assist in helping trainees to feel less shame or embarrassment for accessing this resource.

It may also be of use and relevance for the BPS and HCPC to review current research and make more of a statement on the issue, particularly given the shift to the reflective-practitioner model of training, and the developing evidence that PT may be one way of developing competencies related to this model. Such a statement from these professional bodies may also assist training courses in considering how to approach the topic with trainees. This seems of further relevance given the finding that some participants were reluctant or worried about accessing PT due to the perceived notion that their training course may be discouraging of this decision. The current research will be presented for peer reviewed publications in journals relevant to the practice of Clinical Psychology. It is hoped that this will allow Trainee CPs, the professional bodies, training courses, and potential supervisors to have a more informed basis for decisions around a much contended topic.



In line with prior research participants within this study reported meaningful experiences related to being in the position of the client. It seemed that these participants worked through an experiential learning process which they felt enabled them to better understand their client's perspectives, empathise, and importantly to reconceptualise their views of mental health. The previous literature has described this process as being a socialisation experience to the profession, of which this research supports. Many of the participants expressed feeling that the things they learnt through their experiences in PT could not have easily been taught, and that it was the experiential nature of the learning that made it so powerful. This is an important consideration, as it implies that for this group of participant PT was important to them feeling a genuine understanding of what it is like to be a client, associated with participant's descriptions of greater levels of empathy for clients accessing therapy. Whilst it may not be necessary to have had an experience of PT in order to be able to consider and empathise with clients, what is important and relevant to this group of participants was that they perceived that their understanding of client's perspectives was enhanced via the process of being a client themselves. This lends support for the consideration of incorporating PT into the training of CPs, as it seems that experiencing the emotional process of PT, may enhance understanding of this, arguably relevant to practice.

The idea of mandating PT is a contended issue. Although current research suggests that for the participants who took part in the study, that PT may have helped in the development of competencies related to the reflective-practitioner model, and in better understanding clients perspectives and experiences. Many international training courses now require trainees to have used a minimum number of hours of PT, as a result of evidence suggesting its utility (Malikiosi-Loizos, 2013). Further research would however be necessary to ascertain if PT should be a mandatory aspect of training. Given the potential financial cost and time commitment, it would be necessary for this research to provide some evidence that the use of PT whilst training had demonstrable impacts on clinical practice. This research does however point to the need for such research, and has highlighted some proposed reasons for a professional reluctance to address the use of PT for CPs and Trainees, something which arguably also needs addressing.

## **5.6 Suggestions for future research**

Given the current findings, it seems it would be useful to complete a large scale survey which could help in understanding the number of trainees who may be using PT, what modalities they are using, and how this may impact upon their PPD. This would help in gaining a more substantial understanding of the current relevance of PT to trainee CPs, and in beginning to understand more about how differing types of PT may impact on development in training.

The current study aimed to explore both experiences and development in PT for trainee CPs. It provides a preliminary model of these. Within the sample, participants have developed in the aforementioned ways to various degrees. Some participants also noted that, had they been interviewed at a different moment within their PT, they may have understood their experiences very differently reflecting on times that were perhaps more difficult, which they feel could have impacted on how they responded. Given that both experiences and development are evolving concepts it would be useful to assess these across time, and to perhaps track how participants develop across the course of their PT. A longitudinal design could be useful in understanding this, perhaps tracking experiences and development with the same participants over the course of their PT whilst training. This would arguably help in a more thorough understanding of experiences and development across the different stages of PT whilst training.

The model constructed from the data fits well with the model constructed by Wigg et al. (2011) in understanding that experiences in PT may result in personal and professional developments via the use of reflecting on these within PT, and via the process of being a client. Given this, there is a framework for understanding experiences and development which could be tested using quantitative methods of enquiry. Although I would argue from my epistemological position that these would not assist in providing concrete evidence, they would perhaps help in further testing this particular phenomena at this moment in time, and would fit with the context of evidenced-based practice. In line with this it may also be of use to conduct research which evaluates differences in aspects of reflective practice/PPD between trainee CPs who do or do not use PT whilst training, in order to establish if there are any between-group differences. However, I acknowledge that there would be a number of confounding variables in such studies, which would be difficult and even undesirable, to manipulate experimentally.

It may also be useful, given the current context of the reflective practitioner model, to design studies in which a comparison of differing methods for developing reflective skills could be tested.

It would be useful to replicate the current study with a larger sample, which is more inclusive and representative of the profession in terms of both gender and ethnicity, and which included trainees from a wider pool of courses. Results of such studies could be triangulated with the current research in order to understand experiences and development in more depth.

#### ANY DIFF IN THOSE WHO DO OR DON'T

Results indicated that there appears to be differences in how courses view and talk about PT with Trainee CPs. It would therefore be interesting and relevant to evaluate how courses consider and talk about PT with trainees, and perhaps to understand the rationale for this, and how this may fit with current research.

#### **5.7 Reflections on the Research Process.**

It is difficult to put into words how I have experienced the process of undertaking this research. At times I have felt excited, fascinated and energised - whilst at others - I have felt stuck, hopeless, and panicked. I have learnt an enormous amount about myself throughout, and in some ways it marks something of a bringing together of many aspects of my learning across training. Most prominently I have grappled with determination - of uncertainty, of fear of failure, and of the beginnings of saying goodbye to the project in which I have been engaged in a continuous relationship over the past two years. It has been difficult for me to separate and to say goodbye, as it marks a meaningful ending, and one of many more over the upcoming months. I have however come to learn in the process that every ending may also be a beginning. At times I have felt proud of how I have approached the project, whilst at others I have berated myself for not working harder, or faster. In the end I can say that I have given the project all that I could, and with that I am content.

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## CHAPTER 7: APPENDICES

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## 7.1: Section 1: Systematic Literature Review Tables

### Appendix A: Tabulated Description of Systematic Review Papers

Authors, year & Title	Type & Aim	Participants	Method	Results and Conclusions	Pros and Cons
<p>Digiuni, Jones, &amp; Camic. (2008).</p> <p>Perceived Social Stigma and Attitudes Towards Seeking Therapy in Training: A Cross National Study</p>	<p>Quantitative, multi-national, cross-sectional survey design.</p> <p>To test the prediction that perceived social stigma for receiving PT (PT) would affect trainee clinical psychologists' (CP) attitudes toward seeking PT, and that international differences would reflect differences in social stigma across countries.</p>	<p>462 clinical psychologists in training completed a survey (online and postal); of which 211 were trainee clinical psychologists from England, 130 from the US and 121 from Argentina.</p> <p>For the purpose of this study the focus is on data derived from the English sample.</p>	<p>Participants completed an online or postal survey which included the following measures:</p> <p>Demographic Questionnaire (age, gender, ethnicity, religion, year of study).</p> <p>Questionnaire based on predictors of attitudes towards PT that have been found in previous research (theoretical orientation of the course, preferred therapy type, course faculty's views on the importance of PT).</p> <p>Previous experiences of accessing therapy; dichotomous question on whether they had or had not ever accessed therapy.</p> <p>The Attitude Towards Seeking Professional Psychological Help Scale Short Form (ATSPPH-SF)</p>	<p><b>Results</b></p> <p>Across national groups, participants had positive attitudes towards seeking therapy. The English group had the least favourable attitudes comparatively.</p> <p>Hierarchical Multiple Regression Analysis (HMR) demonstrated that when controlling for course theoretical orientation and trainees' preferred therapy choice, social stigma was a significant predictor of attitude toward seeking therapy across national groups.</p> <p>Data from each national group was imputed separately using the same HMR analysis. For the English group the most reliable predictor of attitudes towards seeking therapy was how course faculty viewed therapy. Social stigma was also a significant predictor of attitudes when controlling for</p>	<p><b>Pros</b></p> <p>This is the only published study that includes UK based trainee clinical psychologists which considers trainees' attitudes to seeking therapy. Thus it contributes greatly to how this is understood.</p> <p>The study considers how perceived societal discourses around seeking therapy, as well as how courses approach the subject may impact on attitudes towards the uptake of therapy. Therefore it addresses how social and professional stigma may impact on the uptake of therapy by trainee CPs in the UK, something which has not been considered in published research.</p>

			<p>Social Stigma Scale for Receiving Psychological Help (SSRPH)</p>	<p>course theoretical orientation and trainees' preferred therapy choice.</p> <p><b>Conclusions</b>  For the English sample, appraisals of the benefits of seeking therapy may be affected by how they think others (e.g. faculty members and the wider society) will view it. This implies the way in which training courses present information on the use of therapy whilst training and the perceived wider societal discourses around using therapy may impact upon how it is perceived and taken up.</p>	<p>On the whole the analysis of the data is sound and consideration of the statistical assumptions of both HMR and ANOVA analysis were met, tests of homogeneity of variances were performed, outliers were removed and based on this as well as the unequal sample sizes across groups, appropriate post-hoc tests were performed.</p> <p>Some likely confounding variables are controlled for.</p> <p>Outcome measures of attitudes towards psychological help, and perceived social stigma have good psychometric properties, internal consistency, test re-test reliability, and cross-national validity.</p> <p><b>Cons</b>  The data is cross-sectional and therefore due to the non-experimental design casualty cannot be determined.</p>
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					<p>Given the design of the study there may have been self-selection bias which could impact on the representativeness of the sample and the generalisability of the findings.</p> <p>No indication was given regarding what would be an appropriate sample size in order to reduce sampling error and there was no consideration of potential differences between responders/non-responders.</p> <p>Based on the literature there may well be other confounding variables that could impact on attitudes, mainly the cost (financially, emotionally and practically) that were not considered.</p>
<p>Nel, Pezzolesi, &amp; Stott. (2012).  How Did We Learn Best: A</p>	<p>Mixed-method, cross-sectional, retrospective survey design.</p>	<p>1,900 qualified clinical psychologists were randomly selected from the Department of</p>	<p>Participants completed an anonymised survey created by the first author, which comprised three sections:</p>	<p>Descriptive results indicated that 26% of the sample had used PT whilst training, 88% of those participants considered it to be an important or very important learning method as part of their</p>	<p><b>Pros</b> The study is the first of its kind to consider which learning methods or activities are considered to be important to training</p>

<p>Retrospective Survey of Clinical Psychologists Training in the UK</p>	<p>To investigate the perceived value and usefulness of learning activities used during training in clinical psychology.</p> <p>Of these methods, Personal and Professional Development (PPD) is considered and PT is considered as a potential learning activity/method to support this. This study therefore contributes to the understanding of trainee CPs accounts of PT as a training method for PPD.</p> <p>Results relevant to PT will be described.</p>	<p>Clinical Psychology (DCP) division of the BPS and were asked to complete a survey either by post or online, evaluating the usefulness of learning activities they had experienced whilst training.</p> <p>357 participants took part; 19% of the overall sample.</p>	<ol style="list-style-type: none"> <li>1. Related to the learning activities or methods which participants had undertaken whilst training and was divided into activities or methods related to: academic, clinical, research, PPD, and general learning. A dichotomous scale was used indicating if participants had been exposed/not exposed to the method.</li> <li>2. The second part of the survey assessed how participants rated and ranked the learning methods of activities they had been exposed to. A Likert scale was used with a range of 1-5, with 1 indicating that the method had been of no importance and 5 that it had been very important.</li> </ol> <p>Participants then ranked the three activities which had best and least prepared them for post-qualifying practice and were asked to state why in an open ended format.</p>	<p>PPD. Of this sample 58% considered PT a very important training method for PPD, the theoretical orientation of this sample were 41% CBT, and 64% Integrative. Comparatively, most participants had been exposed to self-study (95%) and peer support (83%) and these activities were rated as important or very important by most (Self-study – 95%, Peers Support – 84%)</p> <p>Open-ended questions were analysed using thematic content analysis. Five themes were identified, one of which was “The importance of PT for learning”. The authors commented that most, if not all of the participants who had used PT commented on the fact that PT was not part of their training and that they regretted that this was the case.</p>	<p>in clinical psychology from a trainee perspective. It therefore provides an important contribution to understanding what learning methods and activities may enhance development and practice for this population. This has potentially important implications for training programmes.</p> <p>The consideration of PT as a method of learning is helpful in providing an estimate of the percentage of trainees who may use PT as part of training, and how important they considered it to their learning in PPD. This is the first UK based study that has considered this and thus contributes to an understanding of the role of PT in the training of CPs in the UK.</p> <p>Methodological rigour is demonstrated in the analysis of the qualitative data. A clear description of the analysis employed</p>
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			<p>Open ended questions then asked participants if any method or learning activity that had been useful had not been included in the survey, and if they had any further comments to make.</p> <p>3. The final part of the survey collated data on demographics. Including: age, gender, ethnicity, number of years qualifying, whether they trained in the UK, whether they had current or previous experience of being employed in the NHS as a clinical psychologist, whether they had currently or previously been employed by a training programme, and theoretical orientation.</p>	<p>is provided and quality checks are outlined.</p> <p><b>Cons</b> There is little consideration of the sample size that would be necessary in order to consider the sample representative of the population and therefore the results may not be generalizable to the population, particularly given the low response rate.</p> <p>Participants were varied in terms of the number of years since qualifying, and many of the participants had been qualified for 20+ years. However, such retrospective accounts of learning whilst training may not be accurate, as they may be open to recall biases.</p> <p>The authors commented that the survey provided only self-report, and as such represents the perceptions of the</p>
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					<p>participants, rather than observable evidence or facts.</p> <p>The cross sectional design of the study makes it difficult to determine causal inferences around which learning activities may support development and practice.</p>
<p>Moller, Timms, &amp; Alilovic. (2009).</p> <p>Risky Business or Safety Net? Trainee Perceptions of PT: A Qualitative Thematic Analysis</p>	<p>Qualitative.</p> <p>To explore what individuals beginning their counselling psychology, clinical psychology and counselling training think and feel about participation in PT during training.</p>	<p>Participants were 11 trainee Clinical Psychologists, 13 Professional Doctoral students in Counselling Psychology, and 13 counselling Diploma Trainees.</p> <p>All participants completed an open ended questionnaire as part of the study in the first two months of training.</p>	<p>The research is situated within an essentialist-realist framework, as such the analysis is inductive and data driven.</p> <p>Qualitative Questionnaires were designed investigating the relationship between PT and training, whether it should be compulsory, rationales and difficulties with engaging with PT whilst training, and the potential scope of therapy.</p> <p>Questionnaires were distributed among two course groups of counselling psychology trainees (n=17 and there was a 71% response rate), one group of</p>	<p>Data was analysed using Thematic Analysis (Bruan &amp; Clarke, 2006). Two main themes were derived from the data: ‘PT helps me to be a better practitioner’ and ‘PT “costs me”’.</p> <p>PT helps me to be a better practitioner had subthemes of experiential learning, personal growth and development, protecting clients (and trainees) in therapy, protecting and supporting trainees in their development.</p> <p>Trainees talked of the importance that PT could have on their development and practice via being in the role of client, experiencing modelling from their therapist. They could also make links between improvements in</p>	<p><b>Pros</b></p> <p>This is the first UK based study to explore how trainee CP’s view their experiences of PT at the outset of training and how it may relate to their training. This provides a substantial contribution to an understanding of the role of PT in CPs training.</p> <p>The authors clearly specified their epistemological position and how this related to the analysis of the data. Furthermore, they specified their relationship to the research, analysis steps</p>

			<p>counselling diploma students (n=20 and response rate 65%), and one group of trainee clinical psychologists (n=25, response rate 44%)</p> <p>Clinical Psychology Trainees were provided with funding for 10 sessions of PT, whilst counselling diploma and psychology students had to self-fund (PT was a mandatory part of their training whilst it was optional for trainee clinical psychologists).</p>	<p>their own psychological functioning/personal development during PT and how this may result in being able to work more safely with clients. Finally, PT was seen to help with some of the stress which comes with training.</p> <p>Trainees views on mandatory therapy were mixed, with many believing that this may impact on its efficacy.</p> <p>PT “Costs me” included themes: financially, through opening up a can of worms, and by having a negative effect on the course.</p> <p>Authors reported being surprised at the similarities in answers across the professional groups.</p>	<p>were clearly outlined, and quality checks considered.</p> <p><b>Cons</b> Although the position of the researcher was outlined there was little reflection on how this may impact on the data analysis.</p> <p>The researchers were all involved in the teaching of the participants who took part; this dual role may well have influenced which participants chose to take part in the study, as well as their responses. This potentially impacts on respondents and self-selection biases.</p> <p>The CPs in the study were provided with 10 free sessions of counselling, there was little information on the type of counselling, how this was arranged and how decisions were made about whether to use this facility. This information would have been useful in understanding the</p>
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					<p>relevance of this data to the wider trainee CPs population.</p> <p>It could be argued that having funded rather than self-funded PT may well impact on the considered value of it, although this doesn't appear to be the case in this study, with authors commenting on the similarities across training groups.</p> <p>Given that each training group's data were analysed separately, and then combined, it would have been interesting to see the data analysis broken down by group, prior to looking at the data set as a whole.</p> <p>Extracts from the data were minimal and it would have been of useful to have more of a grounding in this. Tables could have been better utilised to assist with understanding the development of ideas from codes to themes.</p>
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<p>Wilson, Weatherhead, &amp; Davies. (2015).  Clinical Psychologists Experiences of Accessing PT During Training: A Narrative Analysis</p>	<p>Qualitative, cross-sectional, narrative.  To explore the experiences of trainee CPs who have used PT whilst training and its role in their PPD.</p>	<p>Participants were ten female qualified psychologists who were asked to share their story of accessing PT whilst training. The average time since qualifying for the participants was 2.85 years (0.5-7yrs).</p>	<p>Participants took part in a narrative open-ended interview that lasted between 52-85 minutes. The interview was aimed at capturing how participants storied there journey of PT whilst training.</p>	<p>Each individual interview was analysed and a map of each story identified. Shared stories were then pulled from across interviews. Four main chapters were identified across the shared stories:</p> <ol style="list-style-type: none"> <li>1) Being a Trainee; this shared narrative was around the impact that training had on participants and how the stress and pressure of the course often lead participants to embark on their PT journeys, that participants felt it was important to be in the role of the client, and participants talked of the financial obligations of PT whilst training.</li> <li>2) Stigma: Shared conversations around the stigma of accessing and being in PT was something that appeared important within the data, particularly when participants were comparing themselves to</li> </ol>	<p><b>Pros</b> The research is the first UK based study to consider how trainee CPs story their experiences in PT and how this may relate to their PPD. The results are situated within the wider literature around therapists' use of PT and offers a contribution to understanding the relevance of PT to CPs in training.</p> <p>The author considered how her role as a trainee CP may impact on how participants are able to talk about their experiences with her.</p> <p>Some of the results resonate with the wider literature on therapists' use of PT and therefore may be credible.</p> <p><b>Cons</b> The author did not acknowledge her</p>
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				<p>trainees who were not having PT.</p> <p>3) The Therapy Process: Participants described waiting until being at crisis point to access PT, the importance of the therapeutic relationship to enable them to make changes, and that overall experiences in PT were positive, although they could leave you open to vulnerability.</p> <p>4) Impact: Participants described how PT had impacted on both personal development, in terms of relationship with self as well as others, and professionally in terms of professional confidence and identity and how this impacted on clinical practice.</p> <p>Conclusion suggested that PT can be a useful PPD exercise for trainee CPs, but that there can be some difficulties that come with the process. The authors addressed how the idea of stigma may impact on how trainees access PT, and recommendations for further research were suggested.</p>	<p>epistemological position or how this may have impacted on the research process.</p> <p>Whilst the author acknowledged that she is a trainee CP, she did not offer an understanding of her views or experiences of PT whilst training or how this may have impacted on the research process.</p> <p>The sample was limited and only included women, it is unclear if all participants trained at the same courses or where they were situated geographically.</p> <p>Although there was some description of the analytic procedure, it was not detailed enough to understand the process, and there was no reference to the type of narrative analysis which was used, how this was decided upon, or how this fitted with the overall framework of the study.</p>
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					<p>Understanding the links between the data, findings and interpretations was therefore difficult.</p> <p>Qualified CPs were being asked to reflect back on their experiences of PT whilst training and offering retrospective accounts. This may impact on the meaning that participants make of their experiences when compared to trainees who are in the process of PT whilst in training.</p>
<p>Williams, Coyle, &amp; Lyons. (1999).</p> <p>How Counselling Psychologists View Their PT</p>	<p>Quantitative, survey data.</p> <p>To investigate how qualified counselling psychologists viewed their PT, reasons and motivations for PT, as well as the outcome and process of PT.</p>	<p>Participants were qualified counselling psychologists, whose details were obtained from a register of chartered psychologists between 1995-1996.</p> <p>The survey was sent to 192 Psychologists, 115 replied (60% response rate). Of these, 84 were</p>	<p>Questionnaires were designed by the authors based on previous research and a piloted version of the survey.</p> <p>The questionnaire had four parts:</p> <ul style="list-style-type: none"> <li>- Demographic data and other relevant data such as PT requirement, number of PT sessions, and number of years in practice.</li> <li>- Decisions about PT, which included theoretical</li> </ul>	<p>Results showed that the number of hours of PT participants had ranged from 0-300 hours, of which 60% felt was about the right amount, 35% felt it was too little, and 5% too much.</p> <p>88% of participants felt PT should be mandatory for trainees, including 69% of the sample who reported some negative effects from their PT.</p> <p>The three highest rated modalities of PT that participants engaged with were: psychodynamic PT (44%), humanistic (26%), and</p>	<p><b>Pros</b></p> <p>The survey set out to gather general information to address how Counselling Psychologists viewed mandatory training and how it related to practice. The use of a survey was appropriate in gathering general information from a wide pool of participants and the data could provide information that could inform subsequent relevant research.</p>

		<p>included and participated (response rate reduced to 44%).</p> <p>Participants completed and returned questionnaires by post.</p>	<p>orientations of participants and their therapist, motivation for PT (measured on a 5 point Likert scale: from ‘not at all’ to ‘extremely motivated’), and if the therapy had an aim (yes, no, don’t know)</p> <ul style="list-style-type: none"> <li>- Evaluation of PT in which participants rated the extent to which PT had contributed to development with regard to various aspects of counselling psychology practice (5 point Likert scale: from ‘didn’t at all’ to ‘contributed a great deal’)</li> <li>- How participants viewed the timing of PT and if it should take place before training, at the start, at the trainees own discretion but throughout training, throughout training, or after training.</li> </ul>	<p>Integrative (19%). Most participants shared the same theoretical orientation as the PT that was sought.</p> <p>89% of participants rated positive effects from PT, and 27% reported negative.</p> <p>Aspects of PT considered relevant to the practice of counselling psychology (those rated fair or to have contributed a great deal to practice) were personal development (77%), understanding the working alliances (77%), and understanding the therapeutic process (73%).</p> <p>Conclusions: The majority of participants were in favour of mandatory PT as part of training. In accordance with this participants mainly rated positive responses to PT. However 27% reported negative effects. In line with prior research the authors suggested considering both costs and benefits of PT.</p> <p>Positive aspects of PT were broad, but learning about therapy was found to be the most influential factor.</p>	<p>The research contributed to an understanding of views on mandatory PT, a topic which has been widely contended in the literature.</p> <p><b>Cons</b></p> <p>The survey was ambitious in its aims of understanding the process of PT, its outcome, and how it is used in practice. Typically, a more robust research design would be used to address process and outcome issues, rather than self-report questionnaire, in which participants had to answer questions using closed questions which may not capture their own personal experiences of process and outcomes.</p> <p>The use of closed questions to address complex experiences is questionable, responses to process, outcome, and how this related to professional practice was based on categories</p>
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					<p>designated by the authors and may not capture subjective experiences. Some participants commented that the questions were not relevant to their own experiences.</p> <p>The authors commented that the mean age of participants was between 40-50, and many may not have qualified via doctoral training. Type of training and differing training experiences may well impact on experiences and view of PT and therefore act as a likely confounding variable.</p> <p>A number of likely confounding variables were not controlled for, such as age, gender, past experiences in PT, and post-training experiences of PT.</p> <p>The authors suggested that looking back at PT in hindsight may remove people from any negative</p>
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					<p>experiences that they had at the time.</p> <p>The design is open to self-selection bias and those who choose to participate may well have had more positive experiences of PT.</p>
<p>Kumari. (2011).</p> <p>PT as a Mandatory Requirement for Counselling Psychologists in Training: A Qualitative Study of the Impact of Therapy on Trainees' Personal and Professional Development</p>	<p>Qualitative, using IPA analysis.</p> <p>To explore trainee counselling psychologist experiences of PT whilst training and its implication to PPD.</p>	<p>Participants were trainee counselling psychologists from one university course. Seven females and one male participated.</p> <p>All participants took part in a semi-structured interview.</p>	<p>Semi-structured interviews were used and analysed using IPA.</p>	<p>Results revealed 4 superordinate themes:</p> <p><b>Experiential Learning:</b> PT was considered a valuable opportunity to gain specific skills and to try to use these in clinical work. These included skills in understanding and developing therapeutic relationships, learning first-hand about techniques, and knowing what it feels like to be the client.</p> <p><b>Personal Development:</b> Participants saw PT as the first stage in a lifelong journey of personal development. This included subthemes of ways in which PT was important to personal issues, having a deeper understanding of self-relevant to practice, and developing insight and self-awareness important to practice.</p>	<p><b>Pros:</b></p> <p>The study set out explicitly to consider all aspects of trainee experience of PT. It has been argued that previous literature only focuses on the positive experiences, meaning that there is little understanding of potential negative experiences and the impact of these. This study gives some understanding of negative experiences and the impact of these.</p> <p>The study addressed questions around the ethics and rationale for mandatory PT during training, something which has not been considered in-depth in prior research.</p>

				<p><b>The stress of therapy:</b> Participants talked about the ways in which PT had helped with managing stress, however PT impacted on stress due to financial pressures, the pressure of completing the mandatory hours, the right time to use PT, and experiences in PT being disruptive to clinical work.</p> <p><b>PT for therapists is essential:</b> Participants talked of initial feelings of anger that they had to use PT, but of changing their views on mandatory PT through experiences.</p> <p>Conclusions suggested that PT may be a useful way of counselling psychologist developing in PPD, however consideration is given to the impact and ethics of mandated PT particularly given the financial and potential emotional impact.</p>	<p>This is one of two papers within the field that interviews participants at the time they are training about experiences of PT. The research therefore provides a different insight, and allows for a comparison of whether there are differences between accounts of experiences.</p> <p><b>Cons</b> The research question was almost identical to a prior study by Grimmer and Tribe (2001) and gave no rationale or explanation as to why, or how this research may seek to further this prior research.</p> <p>Although the author gave some account of reflexivity they did not consider their own experiences in PT and how this may impact on how the data is interpreted.</p> <p>All participants self-selected to take part in the study and therefore may</p>
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					represent a group who found PT particularly beneficial.
<p>Grimmer, A., &amp; Tribe, R. (2001)</p> <p>Counselling Psychologists' Perceptions of the Impact of Mandatory PT on Professional Development - An Exploratory Study</p>	<p>Qualitative using grounded theory.</p> <p>To investigate opinions regarding counselling psychologists experiences of mandatory PT on professional development.</p>	<p>Participants were 14 counselling psychology trainees, or recently qualified counselling psychology trainees (within 24 months).</p> <p>7 participants (trainees) took part in a 15 minute group interview at two time points (the first interview to develop research questions for the semi-structured interviews, the second interview to triangulate data from the one-to-one interviews).</p> <p>7 participants were recently qualified counselling psychologists who took part in</p>	<p>Initial group interviews provided data that was used to inform subsequent interviews and focused on the question:</p> <p>‘What is your response to the inclusion on the course of a mandatory PT?’</p> <p>Individual in-depth interviews were then completed with separate participants.</p> <p>The same participants were then invited back to a group interview once they had completed training and the interview focussed on responses to the inclusion of mandatory PT on the course now that they had finished training.</p> <p>Grounded Theory was used to analyse data and data was triangulated.</p>	<p>Four core categories were developed through the analysis:</p> <p><b>Reflection on being in the role of the client:</b> which included participants believing they could better understand the therapy process for clients by reflecting on their own experiences of therapy, and that they were likely to replicate positive experiences and avoid replicating negative experiences.</p> <p><b>Socialisation Experiences:</b> which included: participants seeing PT as a rite of passage in the professional role; support for the emerging professional; experience of modelling their own; and validation of therapy, either in terms of model or beliefs about what impacts psychological change.</p> <p><b>Interactions between the personal and professional:</b> which included accounts that PT was considered to be an important aspect of personal development</p>	<p><b>Pros</b></p> <p>The study offers a contribution to understanding how counselling psychologists experience mandatory PT, this is a topic which has been widely debated within the literature but with very little exploratory research contributing to these debates.</p> <p>The authors offered reflective accounts of his relationship to the study and how this could impact upon data analysis.</p> <p>The authors used a standardised quality measure to evaluate the research design and analysis.</p> <p>The procedures and methods taken to collect and analyse that data were</p>



		individual interviews.		<p>even when participants initially came with no difficulties, experiences in PT were considered to support the development of being aware of oneself which in turn impacted on how participants understood relationships with clients.</p> <p>Conclusions suggested that mandatory PT lead to a range of outcomes for participants in terms of their professional development.</p>	<p>clearly outlined, and data analysis was presented using a range of examples from data extracts.</p> <p><b>Cons</b> One of the authors attended the university at which the study took place, and was part of the initial group interviews as a participant. Many of the participants were known to this author and had been colleagues. Although this author suggested that this gave him a unique perspective on the process it could be argued that his involvement and prior relationships with participants may jeopardise the validity of the findings.</p> <p>Of the random sample of 14 participants selected to take part in the study, only 7 took part. It may be that those who took part felt more strongly about the topic than those who did not, affecting the validity of the results.</p>
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## Appendix B: Tabulated Quality Review of Systematic Review Papers

Study	Explicit scientific context and purpose	Appropriate Methods	Respect for participants	Specification of methods	Appropriate discussion	Clarity of presentation	Contribution to knowledge
Digiuni, Jones, & Camic. (2008).  Perceived Social Stigma and Attitudes Towards Seeking Therapy in Training: A Cross National Study	<p>The study located the research within the relevant literature, and considered how the role of social stigma and the theory of planned behaviour related to attitudes around seeking psychological support.</p> <p>The research questions and hypothesis were clearly stated alongside an explanation of how these may contribute to an understanding of attitudes towards psychological therapy amongst clinical psychology trainees.</p>	<p>The methods and procedures were relevant to the intended purpose of the study and the research questions.</p> <p>A rationale for the selected outcome measures was clearly stated, and their psychometric properties were discussed in relation to current research.</p> <p>The rationale for selected countries was outlined. However, information on how social stigma related to therapy-seeking between countries was limited. It was based largely around the number of psychologists</p>	<p>Informed consent was provided by participants and the ethical approval procedure was outlined.</p> <p>There was no information on confidentiality, or if participants' data would be linked to their training course.</p> <p>There was no information on any debrief procedure, or whether participants' welfare was considered when partaking in the study.</p>	<p>The authors clearly outlined all procedures for gathering data and gave examples of specific questions asked.</p> <p>The ways in which the data was organised provided an adequate level of detail so the study's design and analysis could be easily replicated. Additionally, readers could determine the adequacy</p>	<p>The data was discussed in terms of its contribution to a theoretical understanding of trainee CPs attitudes towards seeking therapy whilst training, and the factors that may influence this.</p> <p>A discussion of how results related to specific cultural and professional</p>	<p>The paper was clearly written, well organised and understandable.</p> <p>Data was presented coherently and in an understandable format. However, graphical representations of regression models, with potential moderating variables would have enhanced the presentation of the results.</p>	<p>The paper provided a useful contribution to the understanding of factors that may impact on trainee clinical psychologists' attitudes and decision making behaviour when considering PT. This is one of only two studies to consider these factors in a population of trainees, and the first to include UK based trainee CPs. Therefore it contributes greatly to an understanding of the phenomena in the UK and how it may compare with other countries.</p>

		<p>per capita. Considerations of other relevant data as to levels of social stigma between countries would have enhanced the validity of the findings.</p> <p>No indication was given of what would be an appropriate sample size in order to reduce sampling error and there was no consideration of potential differences between responders/non-responders.</p>		of the statistical analyses employed.	<p>contexts was outlined, and implications of how these results may relate to clinical practice were considered.</p> <p>Relevant recommendations were considered, alongside a discussion of relevant design limitations.</p>		
<p>Nel, Pezolesi, &amp; Stott. (2012).</p> <p>How Did We Learn Best: A Retrospective Survey of Clinical Psychologists Training in the UK</p>	<p>The study provides a rationale for the research and provides appropriate context.</p> <p>The purpose of the study was clearly outlined. An explanation of how results may</p>	<p>The methods and procedures were clearly outlined and could be easily replicated.</p> <p>The methods were appropriate for gaining a preliminary understanding of</p>	<p>The survey data was anonymised thus providing confidentiality.</p> <p>There was no information on how consent was gained.</p>	<p>The authors clearly outlined all the procedures for gathering data and gave examples of specific</p>	<p>The data was discussed in terms of its relation to clinical psychology training and within relevant theory</p>	<p>The paper was clearly written, it was well organised and understandable. On the whole, data was</p>	<p>The study was the first of its kind to consider which learning methods or activities are important to clinical psychology training from a trainee perspective. It therefore provides an important</p>

	contribute to an understanding of learning activities and methods that were perceived to be important to practice from the perspective of trainee CPs was provided.	relevant learning activities and methods in clinical psychology training and were therefore responsive to the intended purpose of the study.		questions asked.  An adequate level of detail was given so the study could easily be replicated in terms of design and analysis.	related to practice.  Appropriate implications for practice were outlined and limitations of the study were discussed.	presented coherently.  For ease of understanding, information on the number of years post-qualifying could have been reported in the demographics table.	contribution to understanding what learning methods and activities may enhance development and practice for this population. This has potentially important implications for training programmes.  The research is helpful in providing an estimate of the number of trainee clinical psychologists who may have used PT and how important they considered it to their learning in PPD. This is the first UK based study that has considered this and thus contributes to an understanding of the role of PT in the training of CPs in the UK.
Williams, Coyle, & Lyons. (1999).	The study discussed the research within	The aim of the study was to gather	The survey was mailed to	The authors provided a	The authors discussed	The paper was clearly	The paper provided data which

<p>How Counselling Psychologists View Their PT</p>	<p>the relevant literature and provided a rationale for the study.</p> <p>Research questions were stated.</p>	<p>general information around how counselling psychologists view mandatory training, therefore a survey design was appropriate for assessing general views on PT, whether it should be mandatory, and at what stage.</p> <p>The use of closed questions to assess process, outcome and implications for practice is limited.</p> <p>Consideration could have been given to a more standardised measure such as The Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies (QuIF-CliPP)</p> <p>There was little consideration in the design or analysis</p>	<p>participants on a BPS register of chartered psychologists. It was not clear if participants had consented to postal details being shared for research purposes, or if ethical approval was received from the BPS to use this information.</p> <p>There was no discussion of ethical considerations, confidentiality, or debrief procedures.</p>	<p>clear description of the data gathering procedures.</p> <p>Although the types of scales used to assess certain aspects of the questionnaire were provided. The authors did not provide a copy of the questionnaire, and did not adequately explain many of the potential responses that participants could select for certain questions related to how experiences of PT may</p>	<p>the results within the context of prior research, and outlined the limitations of the study.</p> <p>Implications or suggestions for future research or practice were limited.</p>	<p>written. There were however some issues with presentation. The use of headings and subheadings would have better orientated the reader to the research questions and rationale.</p> <p>Data was not clearly presented and would have benefitted from the use of tables.</p>	<p>contributes to understanding whether a group of counselling psychologists considered that PT should have been mandatory during their training, whether it was experienced as positive or negative, as well as helpful information on what they perceived was the right time to take this up, and factors that would have been helpful in understanding PT during training.</p> <p>The limitations in question design relating to the process of PT and how its outcomes relate to practice make it difficult to use the information. Additionally, confounding variables impact on how these results can be interpreted.</p>
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		<p>as to potential confounding variables that could influence these processes.</p> <p>The authors commented that the participants came from a number of different training programmes with differing routes; analysing participants based on these factors would have added to understanding any group differences.</p> <p>The use of a factor analysis was appropriate, however no power analysis was provided.</p>		<p>have impacted on practice. Nor is there a clear understanding of how the authors determined what constituted the “practice” domain.</p>			<p>Therefore this part of the study should be interpreted with caution.</p>
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## Appendix C: Literature Review Search Strategy

### Part A: Systematic Review Search Strategy

#### Search One

AND	OR
Trainee	Psychologist, Trainee and Psychologist, “Clinical Psychologist”
“PT”	Therapy

#### Search Two

AND	OR
“PT”	Therapy, Psychotherapy
“Trainee”	“Psychologist”, Trainee and Psychologist, “Clinical Psychologist”

#### Search Three

AND	OR
“PT”	Therapy, Psychotherapy
“Trainee”	“Psychologist”, Trainee and Psychologist, “Clinical Psychologist”, “Counselling Psychologist”

#### Search Four

AND	OR
“Clinical Psychologist in training”	“Psychologist”, Trainee and Psychologist, Clinical Psychologist
“PT”	Therapy, Psychotherapy

#### Search Five

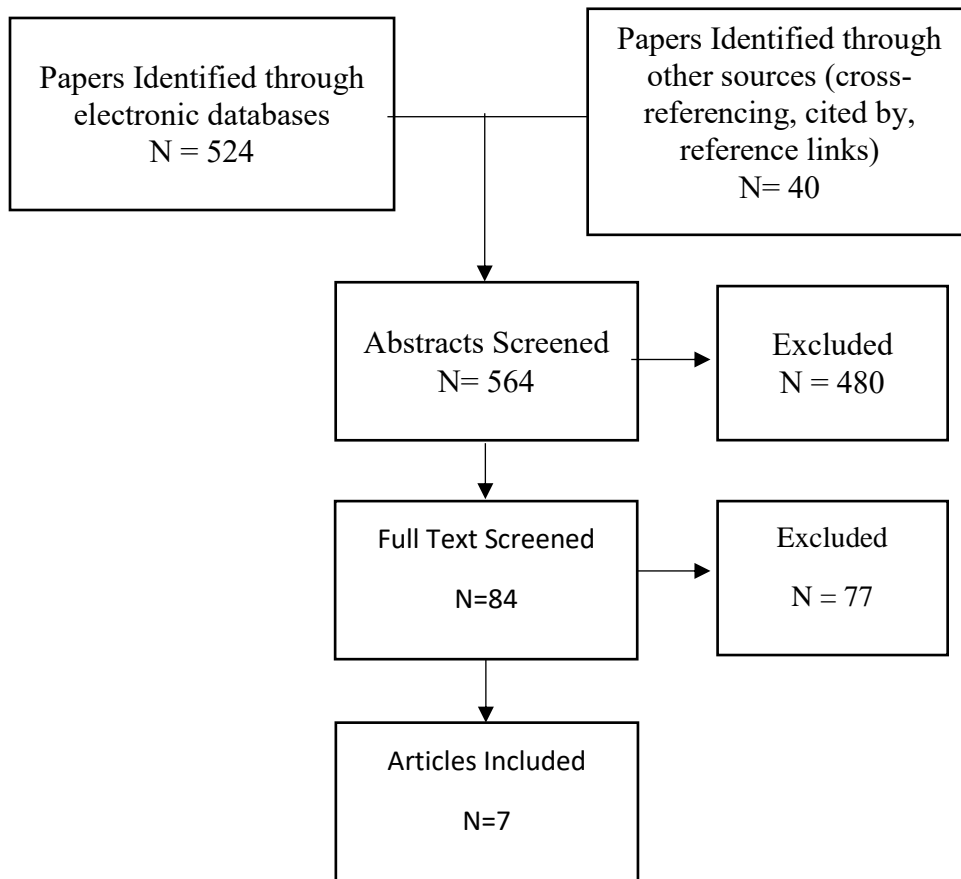
AND	OR
“Trainee”	“Psychologist”, Trainee and Psychologist, “Clinical Psychologist”
“PT”	Therapy
Reflective Practice	Reflection

#### Search Six

AND	OR
“Trainee”	“Psychologist”, Trainee and Psychologist, “Clinical Psychologist”
“PT”	Therapy
Personal Professional Development	

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## Part B: Paper Identification Sources





## 7.2: Section 2: Documents related to Ethics

### Appendix D: Ethical Approval Notification



UNIVERSITY OF HERTFORDSHIRE  
HEALTH AND HUMAN SCIENCES  
**ETHICS APPROVAL NOTIFICATION**

**TO** Elizabeth Malpass  
**CC** Pieter Nel  
**FROM** Dr Richard Southern, Health and Human Sciences  
**DATE** 16/06/16

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Protocol number: **LMS/PGR/UH/02421**

Title of study: An exploration of trainee clinical psychologist's experiences of personal therapy and its relationship to personal and professional Development: A grounded theory study.

Your application for ethics approval has been accepted and approved by the ECDA for your School.

This approval is valid:

From: 16/06/16

To: 28/02/17

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## Appendix E: Ethical Approval for Transcription Services



HEALTH SCIENCES ENGINEERING & TECHNOLOGY ECDA

### ETHICS APPROVAL NOTIFICATION

TO Elizabeth Malpass  
CC Pieter Nel  
FROM Dr Simon Trainis, Health, Sciences, Engineering & Technology ECDA Chair  
DATE 28/03/2017

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Protocol number: aLMS/PGR/UH/02421(1)

Title of study: An exploration of trainee clinical psychologist's experiences of personal therapy and its relationship to personal and professional Development: A grounded theory study.

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Modification: Outsource transcription to transcription services due to time limits of research projects.

This approval is valid:

From: 28/03/2017

To: 01/09/2017

Additional workers: Lesley Beadsley, Becky Adlington.

Please note:

Any conditions relating to the original protocol approval remain and must be complied with.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1 or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit a further EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

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# Appendix F: Confidentiality Agreement for Transcription



Transcription Agreement  
Doctorate in Clinical Psychology  
University of Hertfordshire

## Transcription confidentiality/ non-disclosure agreement


This non-disclosure agreement is in reference to the following parties:

Liz Malpass (Discloser)  
And  
Rebecca Adlington (Recipient)

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:.....  .....

Name:..... Rebecca Adlington.....

Date:..... 18/04/2017.....



## **Appendix G: Participant Information Sheet**

### **Participant Information Sheet**

#### **Title of study**

An exploration of trainee clinical psychologist's experiences of PT and its relationship to Personal and Professional Development: A grounded theory study.

#### **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully. Do not hesitate to ask anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part.

#### **Who is carrying out the study?**

The study is being carried out by Elizabeth Malpass, Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology. The study is supervised by Dr Pieter W. Nel (Deputy Program Director at the University of Hertfordshire and Chartered Clinical Psychologist) and Dr Louise-Margaret Conlan (Clinical Psychologist).

I, Elizabeth Malpass, have both personal and professional interests in the topic of the study having completed PT as part of my training.

The study has received full ethical approval by The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority.

#### **What is the purpose of this study?**

There has been a limited amount of published research exploring trainee clinical psychologist experiences of PT throughout training. Of the limited research that has been conducted none has addressed the process or mechanisms by which PT may be utilised in personal and professional development. The research which is available in the field of clinical psychology points to the need for further clarification and guidance on the use of PT for trainee clinical psychologist (Timms, 2009). The aim of the project is to develop a preliminary, yet substantive understanding

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of the mechanisms through which trainee clinical psychologist experiences of PT are implemented in their Personal and Professional development. Research questions are:

- What are participants experiences of PT throughout training?
- How do participants understand and give meaning to their experiences in relation to their professional practice and personal development?

### **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all will not be communicated to your University and will not impact upon your training.

### **Are there any age or other restrictions that may prevent me from participating?**

You are eligible to take part in the research if you are a trainee clinical psychologist and you have undertaken or plan to undertake four or more sessions of PT through training. You must have already completed a minimum of two of these sessions at the point of interview.

### **What if I am interested in taking part?**

If you are interested in taking part you can contact me by email ([e.malpass@herts.ac.uk](mailto:e.malpass@herts.ac.uk)). We can then discuss any further questions you may have about the study. Once we have spoken you can decide whether you would like to take part in the study. If you decide to take part in the study you will need to read, sign and return the consent form within 7 days.

If you change your mind at any time during the study you can withdraw, without giving a reason. If you decide to withdraw from the study at a later time, your data will be destroyed.

### **What will happen to me if I take part?**

As a participant in the project once you have agreed to consent to take part in the study, the first thing to happen will be to arrange a face-to-face interview with me, the researcher. It is anticipated the interview will last for approximately 60 minutes.

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The interview will focus on how you have experienced PT throughout your training as a clinical psychologist, how your experiences of PT relate to your personal and professional identity and development. Your interview will be audio recorded and transcribed. At the end of the interview we can debrief to discuss your experience of the interview, and any questions you may have.

**Where will the interview happen?**

The interview will happen at a place and time convenient to you e.g., your home address, a room at your university, or a room at The University of Hertfordshire. We can decide this together.

**What happens if you change your mind about taking part?**

If at any stage before or during the interview you decide you no longer wish to continue, you are free to withdraw. You do not have to give a reason for your decision.

**Is what I say in the interview confidential?**

Yes, it is. If you agree to take part in the study your information will be stored in a safe locked location which will only be accessible by the researchers named above. All data information is strictly confidential and is to be anonymised, which means that no names or identifying features will be kept with any of the study information. A randomly assigned coded number will be given to each participant and stored on a password protected document on a secure computer.

The project may be published in a research paper and if your stories are used in the research your identity will be anonymised by changing your name and other details that would identify you.

**What are the possible disadvantages, risks or side effects of taking part?**

The possible disadvantages, risks or side effects to all participants have been considered. It is considered extremely unlikely but it may be possible that you may find the interview process distressing, for example, talking about experiences of PT. In order to protect your welfare, we will take all measures to ensure that you are in the same state as before the interview.

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

Clinical Psychology has now adopted a reflective-practitioner model. It would be useful to have an understanding about some of the factors associated with the use of different paths towards developing these skills. The benefits of taking part in the research are to help improve the understanding of the experiences of trainee clinical psychologists using PT and the processes by

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which these experiences may impact upon personal and professional development throughout training. It is an opportunity to have your experience heard and understood as well as to represent other people who share similar experiences to you. This will be helpful for researchers, professionals of scientific and academic communities, and to the profession of clinical psychology.

### **What will happen to the data collected within this study?**

After all the data is collected, it will be analysed and the study findings will be written in a thesis for doctoral-level research. An article will then be written and submitted to a relevant academic psychology journal for publication. There will be no identifying features or names written in the thesis or academic journal. There may be some direct quotes cited from the interview, however, anonymity and confidentiality is maintained.

### **Who has reviewed this study?**

This study has been reviewed and approved by the University of Hertfordshire (School of Psychology) Ethics Committee and secondary registration has been approved by the The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority.

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The UH protocol number is: LMS/PGR/UH/02421

### **What happens next?**

If you decide, after reading this information and asking any questions that you may have, that you would like to take part in the study we can arrange a convenient time to meet for the interview to take place. I will also ask you to read and sign a consent form and provide some basic demographic information about yourself.

If you would like further information or would like to discuss the details and specifics of the project personally please get in touch with me.

### **Who can I contact if I have any questions?**

**Name:** Elizabeth Malpass

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**Email address:** e.malpass@herts.ac.uk

**Address:** Doctor of Clinical Psychology Training Course, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Although we hope it is not the case, if you have any complaints or concerns any aspect of the study, please write to the University Secretary and Registrar.

**Thank you for taking the time to read this information sheet.**

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## Appendix H: Participant Consent Form

Registration Protocol number: LMS/PGR/UH/02421



### CONSENT FORM

**Project Title:** An exploration of trainee clinical psychologist's experiences of Personal Therapy and its relationship to Personal and Professional Development: A grounded theory study.

#### Statement by Participant

1. I confirm that I have read and understand the information sheet for this study
2. I understand what my involvement will entail and any questions have been answered to my satisfaction
3. I understand that my participation is entirely voluntary, and that I can withdraw up to 3 months after the interview has been conducted
4. I understand that all information obtained will be confidential
5. I agree that research data gathered for the study may be published provided that I cannot be identified as a subject
6. Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification
7. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

Participant's Name .....

Participant's Signature .....

Date .....



**Statement by Researcher**

- I have explained this project and the implications of participation in it to this participant without bias and I believe that the consent is informed and that they understand the implications of participation.

Researcher's Name .....

Researcher's Signature .....

Date .....

## Appendix I: Lone Worker Agreement Details

### Q7. Where will the study take place?

Please refer to the Guidance Notes (GN 2.2.1) which set out clearly what permissions are required; ensure that you complete the Permissions box near the front of this application form and indicate in Appendix 2 (last page of this application form) which permissions you are attaching to the application.

Please enter details here.

Participants will be invited to be interviewed either on campus at the University they attend or at their home address. Permission will be sought from the Universities at the point of recruitment to interview on site.

The focus group will be held at the University of Hertfordshire or at a community location which is proximal to participants. Permissions will be sought according to location.

**Q8.** It might be appropriate to conduct a risk assessment of the proposed location for your study (in respect of hazards/risks affecting both the participants and/or investigators) – this would be particularly relevant for off-campus locations but please consider potential hazards on-campus as well (Question 11 also refers). Please use Form EC5 which is an example of a risk assessment OR use a subject specific risk assessment form provided by your School or Supervisor (See GN 2.2.7 and Section 4 of the Guidance Notes).

If you do not consider it is necessary to make a risk assessment, please give your reasons:

In light of the fact participants will be unknown members of the public there are potential risks to the researcher in conducting the interviews in participants' homes or at a campus location. The researchers' safety is of paramount importance. In line with NHS policy for lone working various precautions will be put in place.

- The supervisor will be aware of the researcher's planned appointments. This includes the address of the location, details of the people they will be visiting, telephone numbers of both the participant and the researcher and expected arrival and departure times.

- The supervisor will have the details of the vehicle being used by the researcher registration number, make, model and colour.

- The researcher will keep the supervisor up to date in terms of their movements, such as if they are late for an appointment, if the appointment is cancelled, and when the appointment has ended and they have left the residence.

- If the researcher fails to make contact with the supervisor within the agreed time frame the supervisor firstly attempts to contact with them via telephone. If this is not successful the supervisor will next attempt to contact the participant they arranged to visit via telephone. If the supervisor is not able to speak directly with the researcher they will subsequently contact the police. The police will be given the researcher's description, phone number, vehicle information, address and phone number of the participant.

### 7.3: Section 3: Recruitment Documents

#### Appendix J: Recruitment Email to Course Directors

Dear (ADD NAME)

I am a second year trainee clinical psychologist at the University of Hertfordshire. I am investigating how trainee clinical psychologist experience and implement personal therapy in their Personal and Professional development during training for my major research project. I am writing to you, and all other heads of training programs throughout the UK, to seek permission to approach the trainees on your course to invite them to participate. I hope that this will ensure a representative sample of the views of trainees.

As you know, personal therapy is not mandatory in clinical psychology training in the UK. There remains debate in the literature about the importance of personal therapy as a means of personal and professional development. There remains little published research in the area, and much of the research has relied on retrospective accounts. I am hoping to expand the research literature on the training clinical psychologist's experiences of personal therapy, and its relevance to personal and professional development.

This study has received ethics approval from University of Hertfordshire ethics committee (registration no: LMS/PGR/UH/02421). Trainees will ask to take part in an interview which will last between 60-90 minutes. They will not be asked to identify the course on which they train and all responses will remain confidential.

I would be grateful if you would consider giving permission for trainees on your course to participate. I will be emailing your course administrator and yourself shortly with full information about the study for potential participants and information on how to take part. I would be grateful if you could pass this on to the trainees on your course. If you have questions or concerns about this study, please don't hesitate to get in touch at e.malpass @herts.ac.uk.

Many thanks,

Elizabeth Malpass Trainee Clinical Psychologist University of Hertfordshire

Supervised by: Dr Pieter Nel, University of Hertfordshire.

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## **Appendix K: Initial Recruitment Email sent to Potential Participants**

Dear Trainee,

I am writing to invite you and other trainees in the UK, to participate in my Major Research Project. I am investigating how trainee clinical psychologists have experienced personal therapy and how this may relate to their personal and professional development. As you know, personal therapy is not mandatory in clinical psychology training in the UK. There remains debate in the literature about the importance of personal therapy as a means of personal and professional development. There remains little published research in the area, and much of the research has relied on retrospective accounts. I am hoping to expand the research literature on the training clinical psychologists' experience of personal therapy, and its relevance to personal and professional development.

You are invited to take part in an interview exploring how you have experienced personal therapy and how it may relate to your personal professional identity and development. The interview will take between 60-90 minutes. If you choose to participate your identity as well as your course identity will remain anonymous. Participation will not impact on your training in anyway. I am really hoping that trainees throughout the UK will see this study as an opportunity to discuss hoe they have experienced of personal therapy, and add to the debate about the use of personal therapy in training

My contact details are in the information sheet if you would like to discuss the study further. I would be more than happy to answer any questions.

Many thanks,

Elizabeth Malpass Trainee Clinical Psychologist University of Hertfordshire

Supervised by: Dr Pieter Nel, University of Hertfordshire, Dr Louise-Margaret Conlan

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## Appendix L: Initial Interview Schedule

Main areas	Questions and Prompts	Domains
<p>What are participant's experiences of therapy through training.</p>	<p>Tell me about what happened, or how you came to decide to have therapy during training?</p> <p><i>Can you describe the events that led up to making that decision?</i></p> <p><i>(Does/Did it have any relation to your training?)</i></p> <p><i>Was there any relevance to the stage you were at during training?</i></p> <p><i>What was it like to make that decision.</i></p> <p><i>How would you describe how you viewed therapy then</i></p> <p><i>Is it the same/different as how you view therapy now</i></p> <p>To help me to understand your experiences, could you describe what happens in therapy</p> <p><i>How did you make the decision of what sort of therapy to have</i></p> <p><i>About how long have you been using/ did you use therapy for?</i></p> <p>I am interested in understanding how your experiences of therapy may have influenced or made a difference to different aspects of your training.</p> <p>(provide prompts if needed –placement, academic, clinical work etc)</p>	<p>Experiences PT</p>

<p><i>TRAINING &amp; THERAPY</i></p>	<p><i>Can you give me any examples of how therapy has influenced these areas?</i></p> <p>As you look back at how you have experienced therapy during training are there any particular moments that stand out in your mind.</p> <p><i>Can you tell me about any positive experiences of therapy whilst training</i></p> <p><i>How about negative experiences of therapy whilst training.</i></p>	<p>PT whilst training</p>
<p>How do participants understand and give meaning to their experiences of therapy in relation to their development in training</p>	<p><b>I wonder are there ways in which having therapy during training has impacted on how you see yourself as a trainee.</b></p> <ul style="list-style-type: none"> <li>- <i>How did you see yourself as a trainee before you began therapy</i></li> <li>- <i>How is that different to now.</i></li> </ul> <p><b>What are the various roles that you take as a trainee and how may these have been influenced by your experience of therapy.</b></p> <p><i>(only prompt if necessary – are there any other areas? For example on placement, at university, with tutors, with your peers)</i></p> <p><i>How might this be different if you hadn't had therapy.</i></p> <p><i>Are there other aspects of your training that may have helped you to develop in the same way as having therapy?</i></p> <p>Can you tell me how your views or actions as a trainee may have changed since having therapy</p>	<p>PT development</p>

<p>Therapy situated within specific training courses.</p> <p>Other people's experience and sense-making</p>	<p><b>What messages either implicit or explicit do you have about how your course values therapy during training?</b></p> <p><i>What do you make of this position?</i></p> <p><i>How do you think that others on the course make sense of your decision to use PT in training?</i></p> <p><i>What about members of the course team, supervisors, tutors.</i></p> <p><i>I wonder if there are any differences in how trainees who are using therapy are perceived by others in comparison to those who are not.</i></p> <p><i>Can you give any examples.</i></p>	<p>Personal &amp; Professional Development in Training</p>
<p>Ending Questions</p> <p>Pulling together/Summarising the interview....</p>	<p><b>Is there anything else you think I should know to help me to understand your experiences of therapy whilst training.</b></p>	



**7.4: Section 4: Data Collection and Analysis Documents**  
**Appendix L: Initial and Adapted Interview Schedule**

**Initial Interview Schedule**

Main areas		Prompts	Domains
Training to be a clinical psychologist		Journey to Training	
PT during Training		<p>Motivation to begin PT</p> <p>When and Why did you start</p> <p>What type of therapy</p> <p>What helped you to make the decision of that type of therapy</p> <p>Experiences of PT during training: different/similar to other periods in life.</p>	PT whilst training
PT & Identity		<p>Has PT had any impact on how you view or conceptualise yourself.</p> <p>Has PT had any impact on how you view or conceptualise yourself in terms of your profession</p> <p>Is there a difference between personal and professional identity can you tell me about how they are different for you.</p>	PT & personal and professional development

Personal & Professional Development		What aspects of training help in personal and professional development?  How does PT help or hinder or interact with these aspects of training?	Personal & Professional Development in Training
Other people's experience and sense-making		How do you think that others make sense of your decision to use PT in training	
Strengths		Have you ever experienced anything positive from experience of PT in training	
Limitations		Have you ever experienced anything negative from experience of PT in training	

**Adapted Interview Schedule following Consultation**

Main areas	Questions and Prompts	Domains
What are participant's experiences of therapy through training.	<p>Tell me about what happened, or how you came to decide to have therapy during training?</p> <p><i>Can you describe the events that led up to making that decision?</i></p> <p><i>(Does/Did it have any relation to your training?)</i></p> <p><i>Was there any relevance to the stage you were at during training?</i></p>	Experiences PT

<p><i>TRAINING &amp; THERAPY</i></p>	<p><i>What was it like to make that decision.</i></p> <p><i>How would you describe how you viewed therapy then</i></p> <p><i>Is it the same/different as how you view therapy now</i></p> <p>To help me to understand your experiences, could you describe what happens in therapy</p> <p><i>How did you make the decision of what sort of therapy to have</i></p> <p><i>About how long have you been using/ did you use therapy for?</i></p> <p>I am interested in understanding how your experiences of therapy may have influenced or made a difference to different aspects of your training.</p> <p>(provide prompts if needed –placement, academic, clinical work etc)</p> <p><i>Can you give me any examples of how therapy has influenced these areas?</i></p> <p>As you look back at how you have experienced therapy during training are there any particular moments that stand out in your mind.</p>	<p>PT whilst training</p>
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	<p><i>Can you tell me about any positive experiences of therapy whilst training</i></p> <p><i>How about negative experiences of therapy whilst training.</i></p>	
<p>How do participants understand and give meaning to their experiences of therapy in relation to their development in training</p>	<p><b>I wonder are there ways in which having therapy during training has impacted on how you see yourself as a trainee.</b></p> <ul style="list-style-type: none"> <li>- <i>How did you see yourself as a trainee before you began therapy</i></li> <li>- <i>How is that different to now.</i></li> </ul> <p><b>What are the various roles that you take as a trainee and how may these have been influenced by your experience of therapy.</b></p> <p><i>(only prompt if necessary – are there any other areas? For example on placement, at university, with tutors, with your peers)</i></p> <p><i>How might this be different if you hadn't had therapy.</i></p> <p><i>Are there other aspects of your training that may have helped you to develop in the same way as having therapy?</i></p> <p>Can you tell me how your views or actions as a trainee may have changed since having therapy</p>	<p>PT development</p>

<p>Therapy situated within specific training courses.</p> <p>Other people's experience and sense-making</p>	<p><b>What messages either implicit or explicit do you have about how your course values therapy during training?</b></p> <p><i>What do you make of this position?</i></p> <p><i>How do you think that others on the course make sense of your decision to use PT in training?</i></p> <p><i>What about members of the course team, supervisors, tutors.</i></p> <p><i>I wonder if there are any differences in how trainees who are using therapy are perceived by others in comparison to those who are not.</i></p> <p><i>Can you give any examples.</i></p>	<p>Personal &amp; Professional Development in Training</p>
<p>Ending Questions</p> <p>Pulling together/Summarising the interview....</p>	<p><b>Is there anything else you think I should know to help me to understand your experiences of therapy whilst training.</b></p>	

## **Appendix M: Adapted Interview Schedule (Interviews 4-8)**

This interview schedule demonstrates the development of the interview questions based on the initial analysis. I try not to prompt around developing ideas unless they come up in an attempt to not lead the participant or be too directive.

### Introduction

(If it is okay with you today I am going to ask you about your experiences of PT whilst training and if these have had any impact on your training and development. I am using GT methodology, and because of that some of my questions draw on how I have understood other people's experiences. It may be that your experience fits with this and it may be that it does not. I am really interested in hearing about it either way, and it's important for the research that I get an idea of people's unique experience.)

- **I am interested first of all in what helped you to make the decision to use therapy whilst training.**

(PROMT for information related to if participants sees PT as imbedded within training process- if so why)

(PROMPT – if decision making was complex then what was it that made it so, was there anything that facilitated making the decision)

(PROMT – If PPD comes up – how is it that they believed that PT may help with PPD whilst training, what was it that lead to that idea, has it helped with this? How would describe PPD)

(PROMPT – If there was some support from training course – what sort of support was there and do they think that this impacted on decisions about PT. What do they make of this position? If there wasn't same prompts)

- **Some people have talked about having a trigger or something that gave them a bit of impetus to begin PT. I wonder if there was something like this for you or not?**

**Tell me a little about the PT you have**

- **I wonder if your experience in therapy have impacted on any aspects of training**

(Prompt – if it comes up that participants are reflecting on being in the role of the client – explore this further – this is interesting as others have talked about this.... I wonder if you can tell me a bit more about this experience, what was it about this that made it an important part of you experience, how do you consider that it has impacted on you, and on you as trainee, any other ways in which being in the position of the client has impacted on how you have experienced PT)

(Prompt – If information related to academic work comes up – particularly reflective practice in written work- then prompt around this for establishing what it is about PT that is applicable

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to academic work and reflection – how does it help- what change does it enable that makes reflecting easier in academic work and more generally.

(Prompt – If information around self-development/awareness come up then ask about these. Interesting as other participants have talked about feeling that they are learning more about themselves in PT, I wonder if this resonates for you, and what do you feel it is about PT that allows you to learn about yourself in that way. I have understood that it may be that part of this learning may happen by people thinking about their interactions with different people within PT – so for example supervisors, partners, friends, colleagues. I wonder if you feel that you may have learnt more about yourself in these ways or if there is something a bit different about how you have learnt more about yourself..... Some people have told me that its actually really difficult to conceptualise and this may be the same for you, so please do take some time to think about it if you need to.)

(Prompt – If self-development/awareness/reflection comes up – in what ways do you feel that X has impacted on your training, are things different because you have this x, what about outside of training, I wonder does this impact on other areas of your life.)

(Prompt – Role as a therapist – I found it interesting that people have talked about being a therapist and having PT at the same time. I wonder what that has been like for you, do you think that this has had any impact on your experiences or what you have perhaps learnt or taking away from your experiences)

- **How you see yourself as a trainee or roles you take as a trainee has PT has an impact on these.**

(PROMPT: Some people have talked about how they see themselves as a trainee, and some of the pressure and expectations that they feel. Some people have used PT as a space to think about some of these ideas I wonder if this resonates with your experience – If yes what have these discussions allowed for if anything.)

- **I wonder if you have had any moments in PT that stand out, or which you feel have been meaningful.**
  - **I wonder if there are other ways that we haven't talked about that are in important in helping me understand your experiences in PT.**
  - **Summarise and Debrief**
-

## **Appendix N: Adapted Interview Schedule interviews 9 and 10**

If it is okay with you today I am going to ask you about your experiences of PT whilst training and if these have had any impact on your training and development. I am using GT methodology, and because of that some of my questions draw on how I have understood other people's experiences. So this may be quite different to other interviews you may have done. I am going to talk to you about some key ideas that I think are relevant to experiences in PT. It may be that your experience fits with this and it may be that it does not. I am really interested in hearing about it either way, and it's important for the research that I get an idea of people's unique experience.

### **Area 1**

Firstly I want to talk you about how you made the decision to use PT. This is something that I have understood has been quite an important decision for people to make. I wonder how you came to make the decision, what it was like to do that..... Was it an easier decision to make?

Draw on what is said and see if it relate to the ideas....

I have understood that people talk of really thinking about the decision and that makes me think that the decision seems quite important. Did it seem like an important decision for you or not really so much. I think that because it can be an important decision that sometimes people almost put it off, or struggle with getting started. But what I have understood is that it may be that people experience a trigger and that this helps them to get to the point of starting PT. Thinking about your experience what do you make of that? Have your experience been similar or not so much.

Contemplating – Believing it is important to the profession –

Trigger - Feeling stressed/distressed/struggling

Committing – beginning

### **Area 2**

I am going to move onto get us thinking about experiences within PT. Now I have understood that central to peoples experience is in learning more about themselves. I wonder if this has been the case for you or if there other aspects of your experience that you think actually are maybe more relevant or meaningful.

How I have understood people learn about themselves is in a number of ways... I'd like to talk you through each and just see what you think about these, do they seem familiar to your experiences, if they do it might be helpful for me to ask you to give me some examples of how, if not I would be really interest in understanding your own unique experiences and what aspects of these were important to you and your training.

- Considering Professional Context – I have understood that people begin to think about how they came to be training, and the process of getting on, and how they imagine they should be a trainee within PT – sometimes I guess this may be because people may have been struggling with some of these ideas. I wonder if you use PT to reflect on any of these issues –
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if yes what and how, what difference did it make if any. If not are there any aspect of your idea of yourself as a professional or your professional role that you have used PT to think about.

- Personal development – I have understood that some people think that they have developed personally, or learnt or understood themselves differently through their experiences in PT. I wonder do you think that this has been the case for you. If so what have you learnt, how do you think that the process of learning that occurred, are things different now you know that. Prompt for understanding via exploring behaviour, and thinking about childhood experiences.
  - Being a client – I have understood that it seems important to people within PT to have a lived experience of being a client. I wonder if you think that this has been an important part of your experiences within PT. If yes, what is it about his that you think is important, how you think that it may have impacted on your role as a trainee or on your practice? Some people talk of kind of modelling aspect of their own PT – I wonder do you that? Is you do what sorts of things you use from your own PT – and what it is like to do that. Have you learnt anything from trying that out?
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## Appendix Q: Examples of Line-by-Line Coding

### Interview 001

P=interviewee R=researcher	Line by Line Codes
<p>I: Okay, so first of all can you tell me about what happened or how you came to the decision to start therapy during training</p> <p>P: ummm. I think the idea originally came from my supervisor when I was an assistant psychologist</p> <p>I: (quietly) okay</p> <p>P: Errrr which was a couple of year before I actually got onto training. Mmmm and (pause) (hesitation) I kinda, I think she recommended training (pause) errr, [tut] errrr therapy (pause) before training because that's what she had done</p> <p>I: Argh Okay</p> <p>P: and then I never really got round to doing it.</p> <p>I: Hmmmmm</p> <p>P: And I think it was more (pause) it wasn't just that I just hadn't got round to doing it I was a bit, sort of (change in tone, gentler) <i>nervous</i>,</p> <p>I: mmmmm</p> <p>P: I didn't know what to <i>expect</i></p> <p>I: mmmmmm</p> <p>P: and I just put it off. Errr and then when I actually started training I thought okay I need to actually get round to doing this now</p> <p>I: Hmm</p> <p>P: cos I've put it off for (pause) a good two years [nervous laugh].</p> <p>I: Okay</p> <p>P: That was where it came from</p> <p>I: So that kind of idea has already been planted by a supervisor</p> <p>P: Yeah</p> <p>I: but then when you got to the point of training you thought, oh okay I've put it off for kind of long enough.</p> <p>P: Yeah</p> <p>I: Was there anything else that influenced the decision at that time?</p>	<p><b>Contemplating Therapy</b></p> <p><b>Preparing for training</b> <b>Therapy being recommended</b> <b>Taking advise</b></p> <p><b>Hesitation around starting</b></p> <p><b>Realising therapy may be anxiety provoking</b></p> <p><b>Not knowing</b></p> <p><b>Putting it off</b> <b>Something I need to do now/Marking the beginning</b></p> <p><b>Putting it off</b></p>

P: mmmm I think, yeah, a couple of other things, so, I was getting more money, and I think  
 I: Hmmm  
 P: actually I wasn't getting that much more money, mmmmm, obviously being a band 6 on training  
 (pause) errr but, it was more sort of job security, so thinking oh I've got something  
 I: mmmm  
 P: lined up for the next few years so I can start it now without thinking, god what if I haven't got a job, in  
 you know, a few months and then I'm looking for something and I have to stop,  
 I: mmmm  
 P: and what if I have to move for an assistant job or something like that, it was kind of, security,  
 I: hmmm  
 P: ummm, but also, what was the other thing I was going to say. Mmmmmm, yeah, I'd heard quite a few  
 warnings about the course being (pause) (begins to laugh) highly, stressful.  
 I: Mmmm (both give a laugh)  
 P: (takes a deep breath) and I just thought (pause) like if I sort this out now right at the beginning  
 I: mmmm  
 P: then Its kind of in place, and it can be useful for me, ummm  
 I: Hmmmm  
 P: rather than getting to a point when I get really stressed and then sort of (pause) finding a therapist and  
 all of that stuff which is  
 I: Mmm  
 P: it will be mmmm probably add to the stress, and I thought I'll do it right now and then  
 I: Okay  
 P: I haven't got to much work on  
 I: yep, okay, yeah, oaky, yep, so that makes sense, so you thought, almost, this could be quite a stressful  
 experience, so why not (pause) start this now rather than at the point when perhaps I am feeling a bit more  
 stressed later down the line.

**Contemplating the right time**

**The right time: Having stability and security**

**Having the right resources  
 Worrying about having to stop**

**Instability of pre-training time**

**Buffering against the stress of the course**

**Marking the beginning/Starting at the beginning**

**Believing it could be useful**

**Starting therapy before getting stressed out.**

**"I'll do it right now"**

## Appendix R: Example of Focussed Coding

(Key: Interview 1: Green, Interview 2: Blue, Interview 3: Dark Blue, Interview 4: Purple, Interview 5 Brown, Interview 6: Red, Interview 7: Orange Interview 8: Black, Interview 9: Pink)

Any data that disconfirms	Focussed Code	Initial Codes	Quotes	Memos
	<b>Contemplating PT</b>	<p>Contemplating therapy pre-training</p> <p>Contemplating therapy before training</p> <p>Thinking about having therapy</p> <p>Starting training</p> <p>Anticipating the beginning of training &amp; therapy</p> <p>Believing therapy could complement training</p> <p>Contemplating starting therapy</p>	<p><i>“Erm, (pause) so, (pause) prior to the course I was thinking about having therapy (R: Ok) and so I knew I’d got a place and I was thinking (R: Mm) I’m looking forward to s- starting and also starting therapy ‘cause I’d kind of thought oh perhaps that’s something that can go, can go along quite well with it”</i></p> <p><i>“and I just put it off. Errr and then when I actually started training I thought okay I need to actually get round to doing this now”</i></p> <p><i>“It was something that I had been thinking about for a long time and even in first year I was thinking about therapy and exploring different options.”</i></p> <p><i>“And then I thought maybe I should just check about qualified therapists, analysts, psychotherapists in my area, I knew of a way to do that. Just an email some and say look I’m a trainee any chance you can give a discount or it wont be extortionate.”</i></p>	<p><i>001: (Therapy is part of training) For this participant it feels like therapy comes hand in hand with training and I wonder why really. This is something I should have enquired more about perhaps.</i></p> <p><i>004: This pp takes you on a journey of how she came to make the decision to use PT whilst training. The way that she talks about therapy and training are indistinct, as though she sees therapy as being part of training. This is similar to P001. It seems as though as soon as she knew that she had a place on the course that she made the decision to have PT. It is something that she had been thinking about prior to training in her assistant jobs. It seems that there is a process for her of anticipating what being a trainee would be like, and that this impacted on her thinking that PT may contemplate, the change process that she would go through as part of being a trainee. For this pp there is an explicit interconnection between Contemplating Therapy, Contemplating Training. The pp is excited about starting training and excited about starting PT which she feels may complement the experience. I ask this pp why she thinks that PT may complement training, unlike in 001 – and this gives a bit more information – and</i></p>

	<p><b>Committing to PT</b></p>	<p>Talking to other trainees before training/anticipating what training would be like</p> <p>Deciding modalities</p> <p>Having ideas before starting</p> <p>Putting out the feelers</p> <p>“yeah ok I’ll have some psychodynamic therapy”</p> <p>Thinking about therapy at the start</p> <p>Thinking about therapy for a long time</p> <p><b>Checking out qualified therapists</b></p> <p><b>Making enquiries</b></p> <p><b>Negotiating trainee rates</b></p>	<p>“I think we had, mm I think even before the course started I thought its something that actually I think Id like to do at some point.”</p> <p><i>“it wasn’t something I’d really thought about, but my clinical tutor suggested that I think about it. It’s not the usual party line at my university, but she’s very kind of psychodynamically informed in her work and her approach and so that was a big factor in me thinking about it”</i></p> <p><i>“I saw them both as really important you know my career is massively important I think. Most people that decide to do this route would probably say they’re worked for a lot of years to get here and so I didn’t you know want to give up my</i></p>	<p><i>makes up part of the 2<sup>nd</sup> category of thinking that having PT is an important part of training. Initially I think that I got quite caught up in the idea that for some pp PT was perceived as just a routine part of training based on interview 001, 004– there was a sense for these participants that the two came hand in hand but that actually this doesn’t occur across all of the data, and it feels like the best fit for what is there is simply that people believe that PT is an important part of training.</i></p> <p><i>17/12 (PT as part of training) – I think that this is a similar process for 001, 004 &amp; 005 therapy and training are indistinct but for 002, 003, 006, 007, 008 its different – there isn’t the same connection between seeing PT as part of training. All participants to some degree speak of contemplating PT as part of training and either implicitly or explicitly commit to the process. Some people talk about committing to PT explicitly as evidenced, however I feel like all of the pp commit to a process of PT whilst training, it feels like a commitment because all pp talk about it as being difficult at times for various reasons (apart from 08), or of taking a lot of time to find a therapist (08). For some pp it is just less explicitly talked about but in talking about the process of PT, organising, the time taken to organise it, that sticking with when it is challenging I feel demonstrates a commitment.</i></p>
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		<p>Considering PT before the course started</p> <p>It something I'd like to do at some point</p> <p><b>Marking the beginning/Starting at the beginning Timing it from the start could make therapy more useful</b></p> <p><b>"I'll do it right now"</b></p> <p>Committing to therapy as part of training</p> <p>It just ohh that's what I do</p> <p>Therapy becoming routine</p> <p>Everything fits around it</p> <p>That's what I do on a Thursday, it just what I do</p>	<p><i>opportunity to get onto training and do it. But also I didn't want to give up the opportunity to have the PT because I thought (pause) that was massively important to my personal development"</i></p> <p><i>"So, yeah, I guess, the commitment of (pause) having, getting onto training and having a job for three years, a regular, sort of routine, and emmm, money, errr sort of helped me to (pause) take, I don't know, sort of take that step towards committing to it".</i></p> <p><i>"Yeah I think there is that tendency to back out and I was like wow is this the right time as in the early stages it was bringing up a lot, and I could have backed out, but I am glad I didn't because I think that I've stuck to it and that the short term discomfort will be outweighed by the long term gain"</i></p>	
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<p><b><i>Believing PT is important to training</i></b></p>		<p>Changing to become more routine</p> <p>Sticking to it</p> <p>Short term costs for long term gains</p> <p>so yeah just really mixed you know mixed but committed.</p> <p>Not wanting to give up opportunity of therapy</p> <p>Wanting to see it through</p> <p>Setting up on a mission</p> <p>Considering it really important</p> <p>“I kind of almost think how could you be a clinical psychologist and never have therapy”</p>	<p>“I yeah always thought it was really important that I’d like to do it and I also always thought that it was strange that it wasn’t mandatory actually in terms of clinical psychology, yeah, to do it, and I thought it was, I, yeah.. I think I suppose I believe it’s essential which is a very contentious and maybe somewhat fundamentalist view.. But I always thought how could that not be essential, yeah..”</p> <p>I think, (small pause) having seen other courses, spoken, spoken with my partner who’s a counsellor and psychotherapist and things, and seeing that every cour- every other type of therapy course (R: Mm) encourage, well, makes it mandatory (R: Mm) that you need to have your own PT (R: Mm), so I guess, I started to question that, (R: Mm) err probably around the time that I started thinking about having my own therapy, (R: Mm) erm, (pause) and I suppose, I was thinking something like if it’s good for the goose it’s probably good for the gander (R: Mm) (R laughs) if it, if it’s recognised as something that is compulsory for so many clinicians (R: Mm) then why isn’t it compulsory for clinical psychologists?</p>	<p>As I brought interview 006 into the analysis, it shifted my thinking about the process of deciding to have PT: I became more aware of people talking about committing to PT as part of training but it shifted me to consider why.... And to re-look at the data which shifted how I looked at the codes and of having a feeling that were a large chunk of focussed codes that I had categorised under contemplating PT as part of training and Committing to PT as part of training but that they didn’t fit with the idea of contemplating/committing. Upon revaluation I broke up these codes further and developed another focussed code around Believing PT is important to training.</p>
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		<p>Feeling its important to have PT</p> <p>Being helpful clinically</p> <p>I felt like I was doing something yes for me but also for my profession and my career.</p> <p><b>Feeling its strange that therapy isn't mandatory in training</b></p> <p><b>Feeling therapy is essential to training</b></p> <p><b>Wondering how therapy could not be essential</b></p> <p><b>"it's I thought while I'm on training now it's even more important to maybe have therapy now."</b></p> <p><b>A good quality in a psychologist</b></p> <p><b>Being a role model</b></p> <p><b>"I guess I would like to say I am an advocate for having</b></p>	<p>"I guess I would like to say I am an advocate for having therapy if you're gonna be a clinical psychologist whether it's during the course or whether it's before the course or as a newly qualified or.. I'm not sure whether the timing matters too much cos I think time is often an individual thing but I do think that if the skeleton is in your closet that actually you would be a better psychologist if you had faced them. Now I'm not saying that everything that hasn't is a crap psychologist cos that's not fair because everyone's so individual, but I do think it helps you in terms of thinking about your reaction to clients; whether that's something about you or whether that's something about them.</p>	
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		<p><b>therapy if you're gonna be a clinical psychologist"</b></p> <p>Believing in therapy</p> <p>"I mean if you go into a clothes shop usually the people who sell you the stuff have the stuff on themselves.</p> <p>" I how can you be convinced in a product if you haven't tried it yourself."</p> <p>Feeling that therapy is valuable</p> <p>Feeling positive about therapy</p> <p>Wondering why PT isn't mandatory in training</p> <p>Believing in having own PT whilst training</p> <p>"I was thinking something like if it's</p>		
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		<p>good for the goose it's probably good for the gander"</p> <p>Recognising that it is compulsory for other clinicians</p> <p>Considering why it isn't for psychologists</p>		
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## Appendix S: Example of the Development of Categories

Key: Interview 1: Green, Interview 2: Blue, Interview 3, Interview 4: Purple, Interview 5: Brown, Interview 6: Red

Focussed Codes	Initial Codes	Q's	Memo	Subcategory	Category	Concept
<b>Committing to PT as part of Training</b>	<p>Thinking about having therapy</p> <p>Starting training</p> <p>Anticipating the beginning of training &amp; therapy</p> <p>Believing therapy could complement training</p> <p>Contemplating starting therapy</p> <p>Having felt positive about therapy for a long time</p> <p>Anticipating being a trainee</p> <p>Talking to other trainees before training/anticipating what training would be like</p> <p>"finding a therapist is the hardest thing in the world"</p> <p>Deciding modalities</p> <p>Putting out the feelers</p> <p>"yeah ok I'll have some psychodynamic therapy"</p> <p><b>Marking the beginning/Starting at the beginning</b>  <b>Timing it from the start could make therapy more useful</b>  <b>"I'll do it right now"</b></p>	<p><i>"Erm, (pause) so, (pause) prior to the course I was thinking about having therapy (R: Ok) and so I knew I'd got a place and I was thinking (R: Mm) I'm looking forward to s- starting and also starting therapy 'cause I'd kind of thought oh perhaps that's something that can go, can go along quite well with it"</i></p> <p><b><i>"and I just put it off. Errr and then when I actually started training I thought okay I need to actually get round to doing this now"</i></b></p> <p><i>006: I saw them both as really important you know my career is massively important I think. Most people that decide to do this route would probably say they're worked for a lot of years to get here and so I didn't you know want to give up my opportunity to get onto training and do it. But also I didn't want to give up the opportunity to have the PT because I thought (pause) that was massively important to my personal development</i></p>	<p><i>001: Memo 2: (Therapy is part of training) For this participant it feels like therapy comes hand in hand with training and I wonder why really. This is something I should have enquired more about perhaps.</i></p> <p><i>004: This pp takes you on a journey of how she came to make the decision to use PT whilst training. The way that she talks about therapy and training are indistinct, as though she sees therapy as being part of training. This is similar to P001. It seems as though as soon as she knew that she had a place on the course that she made the decision to have PT. It is something that she had been thinking about prior to training in her assistant jobs. It seems that there is a process for her of anticipating what being a trainee would be like, and that this impacted on her thinking that PT may contemplate, the change process that she would go through as part of being a trainee. For this pp there is an explicit interconnection between Contemplating Therapy, Contemplating Training. The pp is excited about starting training and excited about starting PT which she feels may complement the experience. I ask this pp why she thinks that PT may complement training, unlike in 001 – and this gives a bit more information – and makes up part of the 2<sup>nd</sup> category of thinking that having PT is an important part of becoming a Psych....</i></p>		Committing	Making the decision to use PT

<p><b>Initial uncertainty about Therapy</b></p>	<p>Committing to therapy as part of training          Not wanting to give up training opportunity          Not wanting to give up opportunity of therapy          Wanting to see it through          Setting up on a mission          Considering both as really important          Considering career important          Working for years to get here          Really valuing it          Feeling determined          Training is important, Living a good life as equally important</p>	<p>006: “Yeah yeah. I’m not sure whether I would have planned to do it whilst on training (laugh) because I guess I knew, I had a realistic expectation of how hard and time-consuming training would be. So I don’t think I necessarily would have thought oh it would also be a good time to do therapy because obviously that’s draining and time consuming. So actually if it had been sort of more of a choice I probably would have wanted to do the therapy first and then do the training and hopefully the benefits of therapy and then start training. But probably yeah to keep them separate yeah, but um the life doesn’t work out like (says this with lower voice)</p>	<p>17/12 Memo – I think that this is a similar process for pp005 as well but feel that for 002, 003, 006, 007, 008 that this different – there isn’t the same connection between seeing PT as part of training. I had initially constructed a hypothesis that PT seemed an integral or integrated part of training as being a potential category, but it seems that this does not seem to be the case when looking at later interviews. .</p> <p>4/01: As I am coding this interview (002) and thinking about the other interviews I am thinking about the reasons why people have used PT whilst training – and this is a question that I asked quite directly, but I think that the way I have conceptualised things so far doesn’t quite capture things – perhaps there is a bigger category which is something around Making the decision to use PT whilst training, and then this splits into people who saw the two as interconnected processes, feeling the need to use PT to cope..... Training, emotional difficulties, life events..... Not sure how this goes..... I guess that what is important about this isn’t what or why they decided to use PT, but how this may then impact on their experiences of PT whilst training, and it seems that however the decision was made the same sorts of experiences seem to occur.</p> <p>006: This pp doesn’t commit to PT as part of training but she commits to PT and she commits to training, she is equally committed to both, but she sees them as separate initially, and feels uncertain about whether having PT whilst training is helpful, worrying that perhaps the pressure of both together could be</p>	<p>Believing PT is important</p>	<p>Contemplating</p>	
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<p><b>and Training Together</b></p> <p><b>Believing that PT is important in becoming a psychologist</b></p>	<p>Contemplating therapy pre-training  Contemplating therapy before training</p> <p><b>Feeling its strange that therapy isn't mandatory in training</b>  <b>Feeling therapy is essential to training</b>  <b>Wondering how therapy could not be essential</b>  <b>Not knowing what it's like to be asked intimate details</b>  <b>Throwing around ideas of resistant patients</b>  <b>Not knowing if you can understand without experiencing.</b>  <b>“um I always thought that surely what, surely you'd be, surely as a therapist you're guided, you're guided or errrr, pushed away from things that are very evocative for you”</b>  <b>Not having a handle on your blind spots</b>  <b>“it's I thought while I'm on training now it's even more important to maybe have therapy now.”</b>  <b>Hoping therapy helps untangle things</b></p> <p>Having ideas before starting</p>	<p><i>that and I saw them both as really important you know my career is massively important I think.”</i></p> <p>I yeah always thought it was really important that I'd like to do it and I also always thought that it was strange that it wasn't mandatory actually in terms of clinical psychology, yeah, to do it, and I thought it was, I, yeah.. I think I suppose I believe it's essential which is a very contentious and maybe somewhat fundamentalist view.. But I always thought how could that not be essential, yeah.. And you know people throw around resistant patients and all that stuff errrr, and I just.. on a straightforward level and obviously peculiarly to me how do you ever have a bench mark for that if you value yourself as a positivist evidence, very evidence-based person.  I think, (small pause) having seen other courses, spoken, spoken with my partner who's a counsellor and psychotherapist and things, and seeing that every cour- every other type of therapy course (R: Mm) encourage, well, makes it mandatory (R: Mm) that you need to have your own PT (R: Mm), so I guess, I started to question that, (R: Mm) err</p>	<p>overwhelming. Its interesting though as she talks it seems she comes to an understanding that actually they may well complement one another, and that perhaps PT may be very beneficial to being the role of psych. Codes from the interview then fit with subcategory – believing that having PT is useful part of becoming a psychologist.  <i>PROCESS: As I brought interview 006 into the analysis, it shifted my thinking about the process of deciding to have PT: I became more aware of people talking about committing to PT as part of training but it shifted me to consider why.... And to re-look at the data for clues about this which I feel were revealed and made up the code – believing PT is important in being a psychologist.</i></p>			
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	<p>Feeling that therapy is valuable</p> <p>Feeling positive about therapy</p> <p>Wondering why PT isn't mandatory in training</p> <p>Questioning why you wouldn't have PT</p> <p>Believing in having own PT whilst training</p> <p>"I was thinking something like if it's good for the goose it's probably good for the gander"</p> <p>Recognising that it is compulsory for other clinicians</p> <p>Considering why it isn't for psychologist</p> <p><b>Being a role model</b>  <b>Be willing to accept help</b>  <b>Working through your own issues</b>  <b>A good quality in a psychologist</b>  <b>"I was conscious that I was going to a job where self-reflection and awareness and robustness, all those kind of things was massively important"</b>  <b>Therapy supporting the development of self-reflection, awareness and robustness</b>  <b>Acknowledging you may not always be psychologically healthy as a psychologist</b>  <b>"I guess I would like to say I am an advocate for having therapy if you're gonna be a clinical psychologist"</b></p>	<p>probably around the time that I started thinking about having my own therapy, (R: Mm) erm, (pause) and I suppose, I was thinking something like if it's good for the goose it's probably good for the gander (R: Mm) (R laughs) if it, if it's recognised as something that is <i>compulsory</i> for so many clinicians (R: Mm) then why isn't it compulsory for clinical psychologists?</p> <p>... I guess I would like to say I am an advocate for having therapy if you're gonna be a clinical psychologist whether it's during the course or whether it's before the course or as a newly qualified or.. I'm not sure whether the timing matters too much cos I think time is often an individual thing but I do think that if the skeleton is in your closet that actually you would be a better psychologist if you had faced them. Now I'm not saying that everything that hasn't is a crap psychologist cos that's not fair because everyone's so individual, but I do think it helps you in terms of thinking about your reaction to clients; whether that's something about you or whether that's something about them.</p>			<p>Trigger:  Anticipating or  Experiencing  distress</p>	
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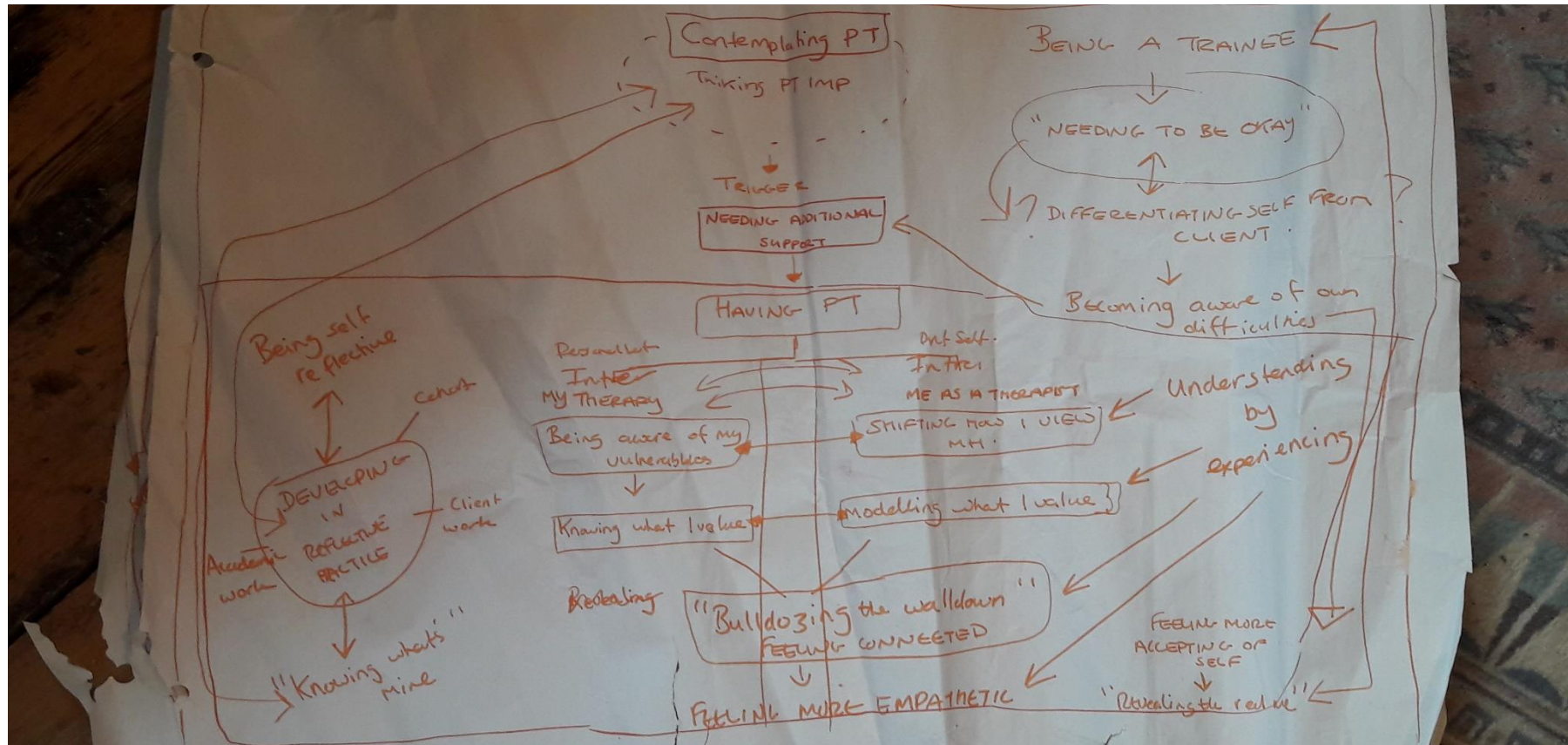
<p><b>Having a difficult life experience</b></p>	<p><b>“I do think that if the skeleton is in your closet that actually you would be a better psychologist if you had faced them.”</b>  I felt like I was doing something yes for me but also for my profession and my career.</p>		<p><i>Memo 15/03/17: I am not sure how to incorporate this... 04 AND 05 talk about it in the same way – so they valued and thought PT was an important part of training but the impetus (trigger) was feeling distressed. I’m thinking that everyone had a triggering event or moment that actually lead them to start PT and so perhaps part of the process is</i></p>			
<p><b>Struggling with the course</b></p>	<p>Having a horrible experience pre-training</p> <p>Starting training at the same time as having a court case</p>		<p><i>Contemplating PT – Trigger – Starting Memo 20/03/16 I’m interested in the idea that there needs to be a trigger..... so it seems like it is not enough to consider if to be useful... I wonder why really- 04 and 05 talk about practical barriers at a time when things are already quite</i></p>			
<p><b>Anticipating Stress</b></p>	<p><b>Feeling distressed being the impetus</b>  <b>Needing an initial push</b>  <b>Making the phone call</b>  <b>Realising I had been putting it off</b>  <b>Not being hesitant</b>  <b>Being put off by the hurdles</b>  I was just quite unhappy  Feeling anxious  Find the course triggering  Not coping with the course  Not enjoying the course  <b>Finding the course really, really hard</b>  <b>Having a big impact on my self-esteem</b>  “oh shit I can’t keep up with this what the hell am I doing?”  Feeling pretty negative  Trying harder to find a therapist  Considering that CBT might be more helpful</p>		<p><i>stressful, I am not sure what I am thinking about this but am weighing up whether it is because its seem like a really important decision – but this may be based on my own feelings about it. Perhaps it is more about needing to feel like there is a reason as it is such a commitment – emotionally, practically, financially....</i></p>			

	<p><b>“I can’t feel like this for much longer I hate this” Wanting to do something about it/Feeling desperate</b></p> <p><b>Therapy as buffering against the stress of the course/anticipating stress</b></p>					
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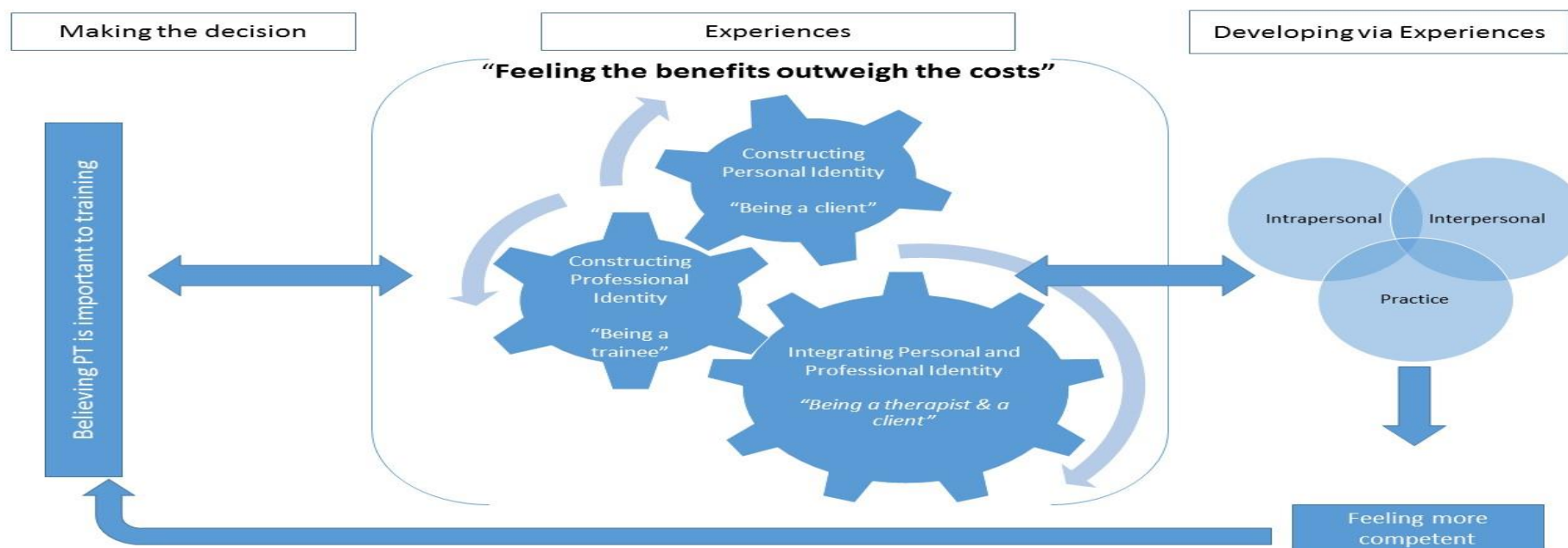


## Appendix T: Example of model development

Stage one of the model development marked a time when I was trying to develop the model from the focussed codes. I had many of these models which I used to try and sort and synthesise focussed codes. As discussed trying to develop the model before generating the concepts and categories was problematic. The diagram is however useful in understanding the beginnings of how I conceptualised the data.

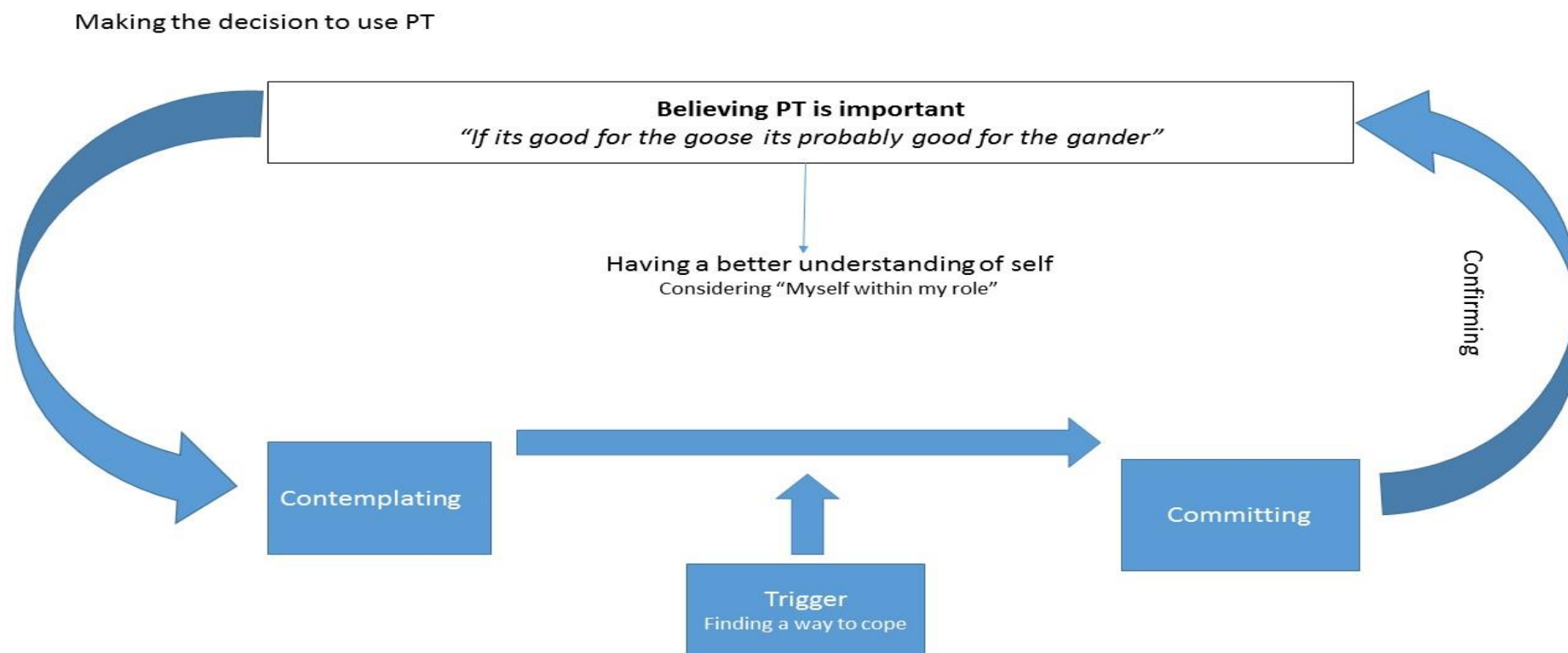


Once I had spent time organising and collating all of the focussed codes generated from interviews one to five, and using maps such as the one above, I began to develop the codes under the concepts of making the decision, experiences and development. When I went back and tested this model against the data I realised that I was trying to force the data into a model and so I went back to the diagrams of the focussed codes, and tried to capture using the participants language what was happening within the data. Many of these models were developed and tested against the data in the early stages of model development.



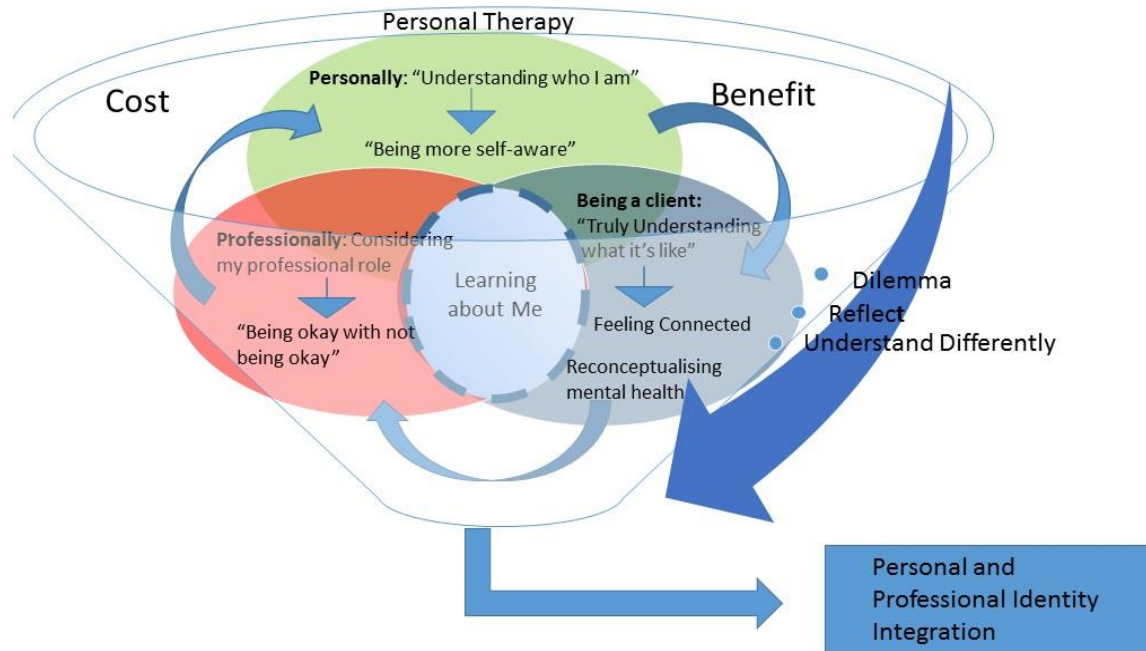
As I worked through the process of developing and trying to understand how the data fitted together I generated a number of models, all based around similar concepts. I choose in the end to use two models to explain the data, as one process seemed to be related to making the decision to use PT and the other to the experiences that occurred within. As can be seen the first model of making the decision initially focussed on my understanding of participants believing that PT was important to training. However subsequent interviews and discussions with participants lead me to understand that key to the experinece is moving

from contemplating to committing, mediated by a trigger. Believing it is important and having a better understanding of the self subsequently became subcategories of the contemplation process.



In developing the model of participants experiences I became quite stuck. It was my understanding that key to participants experiences was in learning at various different levels. I began to think about how they seemed to be learning, and focussed on this in later interviews. I could see that being in the role of the client was key to experiecnes and development, and that this impacted on learning about the self, but I was also very aware that participants seemed to be trying to make sense of feelings of worry and judgement about competency and how this related to being distressed and being in PT. Participants seemed to be making sense of what it meant to be a professional within PT and I didn't want to ignore this data as it seemed relevent. In order to test out whether to include

this category I asked more about the idea with participants in interviews nine and ten. I then used this model below in interviews eleven and twelve to think through the relevance of all categories but with particular emphasis on the category 'learning about me professionally' and whether this related to the other categories and concepts.



## **Appendix U: Concept Development: Learning about being a client**

### **Initial Memo's around this category**

Initially I was interested in the idea that what seemed central to Sally's experiences of being in PT was in her having an experience of being in the clients shoes, which has quite an impact on how she understood the clients that she worked with.

### **Interview 1**

001 Memo: This part of the interview feel particularly powerful for this participant. Having a lived experience of what it is like to have therapy, what it feels like, and being able to understand that and use that understanding to metalize what it is like for clients, it feels really poignant at times when she says Oh God, that is what it is like for people.

001 Memo: Having An experience of being a client allowed for more breadth of understanding of what its like to be a client. Perhaps part of the process of having an experience of therapy allows for more of an understanding of clients which helps to facilitate empathy, and a greater awareness of how difficult it is to talk with a therapist.

### **Relevant Extract**

001: *"going the first few months, I was so nervous, I would come out and my muscles would be like tense (pause) and I was just be like kind of exhausted [body slumps as she says this] , and, just, yeah I found it so tiring and so nerve racking, quite scary, unsafe, which was really interesting for me, cos, I had a real tater for me, kind of, I sort of you know, new that it was scary for people but I really felt it (laughs), how scary it was to go and talk to a stranger , it was just, yeah, far more scary than I thought it ever could be mmm, Yeah, so, that was a useful thing that I learnt in terms of relating it to the course. I guess on my placements, mmm, seeing clients, and mmm, I think it just gave me a better understanding of, errrr, when people seem quite sort of hesitant to come in, or to start therapy to meet new people, and, or scared of change, or mmm any kind of fear or anxiety related to coming in. I'm kind of like, Yeah God, I understand that now (laugh, interviewer draws a deep breath and shares a mutual laugh).*

001: *"yeah it is scary (pause). Mmm, yeah, and its, its, I think it's made me be more empathetic"*

### **Interview 2**

002 Memo: This feel like an important part of the interview. This pp talks about deepening her understanding of being a client through her own experiences and of having an understanding of what she was/wasn't able to convey to her therapist. It seem less powerful than the way it was talked about in interview 001, but nonetheless a similar process. The difference I think is that pp001 learnt through her feelings, at an emotional level, whereas I feel that this pp is leaning about the experience of what it is like to be a client at a cognitive level, about what is able to be conveyed.

002 Memo: As a process of feeling more connected this pp suggest that she is more able to empathise with her clients. Being more empathetic is in allowing herself to be more in touch with her feelings in response to her client's experience.

### **Extract**

002 *"Erm, (long pause) something I noticed was my experience of being a client and h-, and what a limited picture of what I was experiencing I could put across to my therapist (R: Ah, ok, yeah) so, (R:*

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*Mm) I, I'm a very visual person I think in pictures, (R: Mm) and describing that to my therapist meant that only I guess a proportion of that picture got put across, (R: Mm) and so it helped me think about maybe clients being in that position and not feeling maybe able to give every, to put across everything that they want to, (R: Mm) in a session with me erm, not, not being sure how to do that, (R: Mm) erm, or about how I get a better understanding of their experience, erm, based on the disjointed, (small pause) (sighs) comparison to my kind of expressions of what I'm feeling compared to what I'm really, (R: Mm) feeling does that all make sense?"*

*002 "So, (small pause) whereas I had an idea about how to set up a therapy room before and (R: Mm) what I was comfortable with I guess I thought about it more from the client's perspective, (R: Mm) which sounds awful I never thought of a client before (said with a laugh) (R: Mm) having therapy, but erm, I've made more of an effort to kind of simplify therapy rooms (R: Mm) that are just kind of generic NHS therapy rooms covered in leaflets and ridiculous curtains and all of that stuff (R: Mm) (R gives small laugh) so, I've made more of an effort to try and make it as nice as it can be"*

### Interview 3

Memo 003: Comparisons are made between experiences of being a client and applying understanding of this to role as a therapist. This is linked to a process of understanding better client's perspectives. There is a really powerful part of this interview in which she say "I heard his word through mine". For 003, this is about creating a similar sort of relationship with her clients as she is given within her own therapy.

#### Relevant Extract

*003: "I mean sort of taking what I have with him and trying to create that with other people. Yeah so it has been really helpful. I have definitely stolen some of his lines, some of his metaphors, and stuff"*

*I: Can you give me an example of any of those?*

*003: "Deep breathe arghh mmm, I don't know if it is a specific example but when I am crying he kind of just he just tells me it's alright, and he just he is just there with me, and I had a session with the young girl and it was the first time she had cried in the session, and the kind of floodgates opened and it was just like, I kind if heard his words through my words, its okay just let it out, don't hold it in, its okay, its about us accessing our emotions and so yeah I definitely heard him through me there."*

*003: I think for different reasons, I think there is seeing it in action, seeing it demonstrated and then also recognising what it is like to be that client and I guess just having that bit more empathy of what it might be like for your clients and having that bit more empathy. I think personally with my therapy I think why aren't things going quicker and I think with my own clients you know maybe they feel the same and are getting impatient, why aren't they going quicker, and you know it could be a real long process and I guess I'm just not very good at applying it to myself*

### Interview 4

004: Memo: Learning about how "therapy should go". She talks of learning about therapy from having therapy - something that is related to the experience of learning through being a client. It's quite different to how others talk about it this but the essence is the same. This participant is learning about how therapy should go through having her own therapy. Using strategies that her therapist would use with her that she explains she never would have used without having experienced them, I feel really strongly connected with the idea of learning through feeling in this interview as I did with interview 001, 003. This participants needs to 'feel' what a technique is like in order to appreciate its value or limitations. I think then that perhaps part of this process is in 'feeling what its like to be a client'. She talks quite strongly about now understanding how hard therapy is in a similar way that

other participants have – which may be part of a focussed code around understanding the clients perspective - but I feel that perhaps it is something a bit different

Memo 004: Modelling... this participant is modelling her own therapist - Therapist use of self – it something that she had read about and been taught about but didn't believe that it could be useful until she had an experience of this. It seems that a process of how this pp experiences of PT are impacting on her Professional development is via modelling aspects from her own PT that have been useful in her own practice. This is something which all participants have talked about but it seems like for some participant (004, 001, 002 it is quite a direct copying) but for 003 it is both copying words but also modelling the therapeutic relationships.

### Relevant Extract

“I think, I guess, hearing about it in teaching, before actually experiencing somebody using that with me, (R: Mm) made me think oh wouldn't that make the person feel bad because you're telling them they've told you something that's made you feel sad (small laugh) (R: Yeah) but actually to have that experience myself, and to feel actually that didn't make me feel bad that she felt sad it made me feel that she was connecting with me in some (R: Mm) way, (R: Ok) I think that was, useful for”

### Interview 5

Memo 005: I feel that for this pp the most powerful learning experience she has had to help her navigate being a therapist is having a lived experience of PT, being a client, and in having had an experience of being emotionally unwell. She talks about it across contexts but repeatedly. It comes up in all the other interviews but is particularly poignant in this interview.

20/12 Memo: As I code interview 005 and go back to the data I am unsure about how I have labelled this category, it captures something for all the participant of “being the client” and understanding what it is like to be a client. I am not sure if the process is learning through feeling, or if it would be better labelled experiential learning – which I guess are similar....

### Relevant Extract

*005: And just little things I guess, I like in a waiting room for therapy things that I valued and things that I didn't. But if I never sat in that waiting room then as a therapist I probably would have, I'd probably never really think about the small things.*

*005: : I think it's the same for any sort of life experience, until you've had a car crash you can't necessarily appreciate all the things that go along with a car crash. The little things you don't think about you know actually in terms of what should I do now.*

*005: “So yeah I guess I think there is something deeper or more more powerful I guess about actually being in the shoes of somebody almost even though you're never quite.. but yeah I do.”*

### Memo's related to developing the concept

22/12/17: Memos: Being a client: I am understanding that there seems to be a powerful process for participants in having an experience of being a client. It almost feels somehow like a parallel process of being a client, experiencing this – which I think involves feeling what it is like, I don't know how to conceptualise this but is learning by feeling or experiencing – it seems less about a cognitive aspect of learning. Then these experienced are applied in own practice. It make me think of a process of:

Me in Therapy-----Me as  
Therapist

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Being a client -----Being a  
Therapist

Learning from being a  
client.....About being a therapist

At this point I had pulled together all of the initial codes around this idea of the experience of being a client and began to review these by grouping them into what I understood as processes involved in what at this point I was conceptualising as “Truly Understanding what it is like” and developing focussed codes from these.

## **Potential Processes Considered**

### **1) Being the client: Noticing the experience**

#### **Relevant Quotes**

*004: something I noticed was my experience of being a client*

*006: “really truly understand actually what it is like to be on the other side of it”*

*001: which was really interesting for me, cos, I had a real tater for me*

*002: yeah I think it made me just a bit more aware of what that’s like (R: Mm) when coming to therapy and talking about difficult things*

*003: I think there is seeing it in action, seeing it demonstrated and then also recognising what it is like to be that client*

01/2017: Memo: Truly understanding what it’s like: It seems that participants perhaps first of all begin to notice their experience of being a client (Recognising my own experiences). Then to various degrees they are able to apply their own experiences to their clients. So there is something about understanding client’s points of view, or positions, or experiences via applying their own knowledge of the experience to clients.

#### **Initial Codes**

Seeing it in action

Recognising what it is like to be that client

“I think it’s something it’s a difference to understand something or think you understand and know something but also actually having had that experience.”

Experiencing being the client

Being on the other side of it

Having a deeper understanding of being a client

Believing its important being on the other end of

### **2) Understanding through Experience**

#### **Initial Codes**

*“I’m kind of like, Yeah God, I understand that now”*

Deeping understanding of what others feel in therapy

Developing understanding through own experiences

Understanding people’s hesitation to start therapy

Understanding difficulties with engagement

Understanding clients fears and anxieties about starting therapy

Understanding how difficult it is

Realising how difficult starting therapy is for clients

Being aware of what’s lost in translation

“only I guess a proportion of that picture got put across”

Understanding the limit of what clients may be able to express

Understanding the limitations of what can be conveyed in therapy

Being struck by the complexities of expressing self



“I’m seeing something in vivid colour and maybe it comes across as duller colour to the therapist”  
 Understanding that there is more than the words that are said  
 Learning through own feelings: Scarier than anticipated  
 Experiencing my Therapist sharing their feelings  
 The difference between hearing and experiencing techniques  
 Understanding through experiencing  
 “I guess if you had a personal experience of something it often feels more powerful than just reading about how something works.”  
 “I think I’d kind of heard of those sort of things that you can do in therapy and erm, but never really... never really used that myself and wasn’t quite sure how to use it...”  
 Feeling listened too and understood through experiencing therapist being open about her feelings.  
 Making someone feel more heard  
 Having the experience myself  
 Understanding the usefulness of being validated  
 Learning from my own experiences of being a client  
 Shifting ideas about how people engage with therapy  
 Wondering how to understand client’s experiences after having an experience of not feeling able to express self.  
 Having a personal experience of techniques  
 Being surprised by how the technique felt  
 Experiencing it made it feel okay to use  
 Realising the impact after having experienced the technique  
 “That’s been useful to kind of see what that feels like”  
 Hoping it feels the same for clients  
 Understanding the emotional impact of techniques having experienced them  
 Appreciating the emotional burnout of therapy  
 “But when you’re actually having to sit there and wait for therapy like how close the chairs are; or whether the door is left open or closed; things like that were really important to me cos I didn’t want to sit really close to somebody and I didn’t want the door to be open because I didn’t want anybody walking past to see in”  
 Thinking about the little things differently  
 Having a lived experience  
 “until you’ve had a car crash you can’t necessarily appreciate all the things that go along with a car crash.”  
 Appreciating the details  
 Appreciating detail  
 Understanding the little things  
 Missing details if you’ve not had an experience  
 “So yeah I guess I think there is something deeper or more more powerful I guess about actually being in the shoes of somebody almost even though you’re never quite.. but yeah I do.”  
 Understanding how anxiety provoking it is  
 Realising how long it took me to open up  
 I just think wow, you’ve done really well because it took me so long to just open up.  
 Appreciating how hard it can be

Memo: Learning through experiencing. It seems that participants are learning about clients experiences through their own. As a kind of experiential learning. I am interested in the ‘feeling’ aspect of this so participants seem to be learning through the emotional experience rather than intellectually and this is important to capture in labelling the code. I am not sure if it should be Learning through feeling/Experiential Learning/”seeing what that feels like”

### **3) Process: Applying own experiences in clinical practice: “So, I try, I do that with all my clients now.”**

*12/01 Memo – I have put these codes together as they are describing doing something in clinical work that has come about from experiences of PT – but for 001 it is quite different than for 004. For 001, she directly copies things her therapist has used with her that have felt good. Whereas for 004 it she hasn’t directly copied her therapist, its more that she has had an experience of the therapy space and has tried to work towards re-creating. I suppose it is similar, perhaps space is more important than words for pp004.*

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29/12 Memo: I wonder if for pp 006 that this process is happening as well but it is much more subtle – what she valued in her own PT was the TR and using this to make progress and then throughout she talks about how she values the TR as the most important part of working with clients. I am not sure if this fits here. But within this category it seems that all pp have taken some of their experiences from their own PT and applied these to their clinical practice.

16/01/17 As I am thinking about this I wonder whether each pp models the thing they have found to be of value – 004 maybe it's the space/ the containment, 001 phrases, endings, space, 002, using self, maybe for 006 – appreciating that the TR is what leads to change. It something about modelling or using what has been helpful in their own PT.

### Focussed Codes

Noticing that little things make a difference  
Checking things are in order now  
Recognising what is useful to me  
Trying to use what has been helpful to me  
Nicking phrases  
Learning movements  
Learning from good experiences in own therapy  
Understanding what makes me feel good  
Creating a natural ending  
A fragile way to end sessions  
Not wanting to end abruptly  
Feeling more sophisticated  
It's the way she says it  
Nicking things that work  
Feeling like a better therapist  
Tricks as helpful  
Setting up a therapy room  
Simplifying the therapy space  
Making more of an effort to make things nice  
Complaining when rooms are not good enough  
Knowing what I valued  
Knowing what is good enough  
Knowing what I valued  
Not having a tolerance for NHS therapy rooms  
Sprucing things up for clients  
Expressing feelings with clients/Applying own experiences in practice  
Modelling this skill in own practice  
Finding it useful not sticking to structure  
Using self-disclosure  
Feeding back feelings to clients  
Hearing about something differs from experiencing it  
Checking people have time to process after sessions  
Having a space to reflect back what's been discussed.  
Wanting people to have space after sessions  
I should try this way of doing it  
Wondering if clients feel the same as me

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“and that is my ultimate goal really, to be able to do that with my clients” – slightly different as not implementing what has learnt but of wanting to replicate the experience.

Trying to create what I have with him with other people

I have definitely stolen some of his lines, some of his metaphors, and stuff.

I kind of heard his words through my words,.

“trying to really you know foster that with the people that I work with”

Pausing

Leaning to pause

Applying experiences in my own practice

Noticing what comes up in the relationship in my own practice

Using the therapeutic relationship

Commenting on process

I should try this way of doing it

*And I'm thinking like this is good I should try this*

Initially these were the focussed coded that I which came under an idea around the learning experience of being a client. I grouped them under what I felt was a category, as it seemed to be the essence of what I feel the processes were describing.

Learning about being a client (Category) which involved – Subcategories Recognising my experience of being a client, learning through my own experiences, Applying learning in practice.

I then went back and tested this ideas against the data across interviews 1-6. From doing this I created another Focussed code which I felt was relevant to this developing concept:

#### **4) Understanding the client's perspective**

##### **Focussed Codes**

##### **Thinking about it from the clients perspective**

##### **Memo:**

Considering clients perspectives

Having a different perspective

Considering what I was comfortable with

Thinking about what it might be like for the client

Wondering how that might be for own clients

Wondering how that might be for clients

Understanding the client's perspective

Being more aware of what it's like for clients

I also became interested in the following codes and ideas which I had initially consider separate processes but as I went back to the data I realised perhaps related to the ideas above.

#### **5) Making changes in how I perceive myself and clients: “I feel, like the line between therapists and clients has been blurred more now”**

17/12: This comes up in 001 and in 006. I need to look out for how it is talked about in other interviews. I feel like I need to make sense of the process and make it a bit clearer. I am unsure if it is something about PT making people more aware of their own emotional vulnerabilities which makes them more aware of that emotional distress exists in everyone and that there are varying degrees of how this may impact on people. There is something about being more in touch with vulnerability or distress that allows for the distinguishing between professional and client to be broken down.

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19/12 Memo: As I go through and focus code interview 005, and think about the codes together, I wonder whether there is something more than making changes to the way I perceive clients and if it is the shift is in how pp perceive mental health? It certainly seems this way for pp005, and in 004 and to some degree in 001.

001 Memo: As she talks about her own experiences of stating PT, she struggles with it and doesn't quite know how to conceptualise what she talks about. It seems that she wants me to know that she doesn't have a mental health difficulty but at the same time she doesn't want to be "defensive" and she doesn't want to say she doesn't have a problem, she is not sure what a problem is. It feels a bit like she is sort of working out in her mind what does substitute a mental health problem, and perhaps that she has shifted in thinking that she doesn't have any difficulties, to acknowledging that perhaps she does, it feels like this is a bit of a journey for her throughout the interview, in which she ends up thinking that actually her and her clients share similar experiences of emotional distress.

001 Memo|: Positioning: self in therapy: I am interested in how this trainee is positioning herself here. I feel like there is a dilemma or confusion for her about how to define herself in this role, is she a client, a trainee, a person. I feel that she wants me to know that she isn't having therapy because she has a mental health difficulty. Its for her PPD but then it seems like it has become more than that. As she talks it seems as though her own understanding shifts from I don't need help to a position of actually relying on therapy to cope with current life stressors. It feels like she ends up well and truly in the position of a clients, and actually taking a step back from the fixed role of a professional.

004 Memo: In a similar way to pp001 this pp through the experience of therapy has started to reconceptualise how she thinks about clients. It seems that there is something in a transition in thinking about the role of the client & the professional. So instead of having very fixed roles there is more a recognition that actually both people are just people. The line between professional and client has been blurred. There is an acknowledgement that this has something to do with being more in touch with own emotional distress and actually shattering an illusion that I am okay, and that everything is okay with me, perhaps the process of this happening is in acknowledging and being in touch with her own emotional distress allows for more of an understanding that emotional distress is common to all, regardless of whether you are a professional or not. It seems that it has shifted this pp idea of mental health as existing on a spectrum. Although she is clear that her experiences are somewhat different, it feels as though there are some shared emotional experience.

18/12 Memo I am not sure yet about how this process unfolds. There is something about breaking down barriers – connecting, being closer to, and being emotionally closer with clients. I think that this links into thinking about positioning and professional roles. It sort of feels like before PT there was this idea of a professional/trainee as being – well I have to be okay, well put together, almost I would argue verging on emotionally superior- somehow through the process of PT this shifts, there is an acknowledgement that actually the isn't such a line between client and professional..... I think somehow in the process there is also something about "being a trainee". I think that these codes seems to fit with this..... Perhaps drop them in here????

Memo: 006: PP006 has a similar experience as 001 and 005 in that it seems that through her experiences, she sees herself as being less distinct from her clients, she acknowledges the shared emotional distress and that they are both humans. 005 process is different from 001 and 004, who both get to this point it seems by being in touch with their own vulnerabilities and distress in PT. PP005 was already in touch with and aware of her vulnerabilities and this is what helped her to make a decision to use PT, so although she acknowledges that her and clients are not that dissimilar in terms of the experiences of emotional distress, she doesn't work through the process of being more in touch

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with her vulnerabilities. She also acknowledges that she comes to therapy and to MH services as someone with more power and authority than many of her clients.

Memo: 19/12 I am thinking about whether to split this category into two processes – one which is something about feeling less of a distinction between self- client, and then perhaps this then shifts or impacts on how pp see MH more generally ? For pp 004, 005 its seems that there is another process whereby they see MH differently as a result of how their thinking about themselves and their clients has happened though experiences in PT. this links with the extract below....

005 “And I guess you know partly through my therapy there was the kind of the realisation and acceptance that it’s not about being mentally ill or not being mentally ill it’s just about something a bit broader about kind of I guess accepting yourself and your past and what’s happened and moving forwards but also knowing that anybody at any point is at risk really of having mental health difficulties and bringing them into contact with services. “

004: “and it’s kind of more on a spectrum, (R: Mm) erm, so, I guess thinking about myself and clients, as having had more shared experiences, albeit different, (R: Mm) so I guess having had similar categories of experience but not obviously the same experiences (R: Mm) does that make sense?”

These memo’s and related codes eventually formed part of a sub-category: “Reconceptualising Mental Health: Breaking down that barrier” – The memo’s and the thinking around these ideas also shifted how I was understanding that via experiences and learning that happen as a result of being a client that participants also seem to be shifting in how they are thinking about their professional and personal identity. Participants begin to feel a shift in how they experience themselves in relation to their clients – rather than being a client and a professional, it is more a client and another client, or two people. This related to the overall model developed as even though there are different bubbles representing differing experiences and development – the learning each contributes and connects to the learning in the others....

## **6) *Distinguishing Self from Client***

Initially when I had analysed the first four interview I had an idea from the memo’s and codes below that participants worked through a process of initially distinguishing themselves from their clients and that through experiences of being a client, and being more emotionally vulnerable that they considered themselves as less separate. This idea held true for some but not all participants and I think that this is because of how I was understanding this. I think that participants before experience in PT do see themselves and clients as somewhat ‘different’ and but that it seems through analysing the data that his may be more related to how participants understand their roles as a professional with clients, which initially conceptualised as quite rigid. I’ve understood that participants through the process of experience in PT move to these being less distinct.

002: Memo: It is interesting that the pp distinguishes herself form the role of “client” here. She perceives herself as being different to her clients. They have MH issue and she doesn’t. This is quite different to interview 001, 004, 005 where the pp talk about how therapy has removed some of the distinction between them and their clients – made them be more open to their own experiences of mental health difficulties/emotional distress. I think that for this pp she doesn’t shift in how she experiences her own emotional wellbeing as a result of PT, she does however share an experience of being more open to her own emotional vulnerabilities, and part of what she has valued in her experiences of PT is in having a realisation that everybody has struggles or difficulties – I think that the difference here is that she doesn’t apply or talk about this in terms of her clients, more in terms of her cohort, or “other trainees”. She

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doesn't explicitly compare herself with clients. ??? whether this perhaps in part because she has very time-limited therapy in comparison to the others. I

*Memo: 18/12: It seems that there is an initial rejection of the ideas of being the client, or having any difficulties. I really felt this in some of the interviews, that there was a real sense of embarrassment about how I as the interviewer might think about them – it felt like people were eager to explain to me that they didn't have emotional difficulties and that they were using PT for PPD – it seems that as they have gone through PT though they have perhaps then shifted to being more in touch with their vulnerabilities and this has shifted how they position themselves in relation to their clients*

### **Relevant Extracts**

001 “and I wasn't particularly vulnerable, I was just, I didn't go with any particular sort of difficulty at the time (pause), it was more kind of personal and professional development (pause) or that's what it started out as..”

002: “I guess I'd be working with people with mental health issues, (R: Mm) and I didn't really perceive myself to have a mental health issue”

004: I kind of went into therapy thinking I'm a very well put together person, (R: Mm) erm everything is absolutely fine,

### **Focussed Codes**

No considering self to have emotional difficulties  
Not perceiving self as having a MH issue  
Thinking I was well put together  
Not coming with any difficulties  
Struggling with taking the role of the client  
I don't have problems  
Not having MH problems  
Differentiating self from clients  
I don't have problems trusting people  
Being a functional person  
and I am really functional person  
t doesn't feel like I am having therapy cos I have this massive problem.  
Do I have a problem/what is a problem?

#### **7) Recognising own vulnerabilities**

Memo: I am not sure if I have understood this properly and the codes don't seem to fit with this. I'm starting to think that there is something in the process of being distressed that perhaps brings people closer to the experience of being a client that then helps them to understand that there isn't so much of a distinction between being WELL-UNWELL – that allows for a break down in the barrier between client – professional and more of an engagement in the idea of “humanness”.....

### **Focussed Codes**

Noticing shared emotional experiences with clients  
Recognising I have things in common with my clients  
Thinking about my own vulnerabilities  
Realising things aren't as rosy as they seem  
Talking about the painful stuff  
Enacting something you've read about you thought that would *never* happen to me and you're in that position  
Showing vulnerability  
Considering helping others as a defence

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Defending against being in a vulnerable position  
“I’m okay, I’m okay but you’re not though”  
Let me look after you  
Choosing the carer rather than the cared for role  
Needing to please people  
Understanding my need to be wanted  
Needing to be accepted  
Looking after others to avoid being looked after  
“I guess trying to pretend that you haven’t got any difficulties makes you a little bit less human”

## **Feeling more connected: Bulldozing the wall down between us**

### **8) “Feeling more connected”**

Memo 003: Implying that by being more genuine in expressing own feelings in relation to client allows for a greater connection. “Connecting” – as involving use of self, or expressing own feelings implying that by being more genuine in expressing own feelings in relation to client allows for a greater connection.

“Connecting” – as involving use of self, or expressing own feelings

Memo: 005 talks about this idea of being able to be more connected but I think that he talks about it at an intellectual level – rather than grounding it in his own experiences and perhaps it is that I should have asked him more q’s about how this related to his own experiences but this is something to reflect on in the results section....

Memo 002: This pp has an experience of feeling more connected to her therapist through her therapist use/sharing of her own feelings. I have coded feeling connected elsewhere – but it has been in participants feeling more connected to their own clients as a result of being in the position of the client, ,and being in touch with their vulnerabilities. For this pp it is a bit different, I feel that she has the same experience but in a different direction – so she feels more connected to her own therapist through her therapist reflecting upon her own feelings – so via her therapist being in touch with her own feelings in response to her she feels more of a sense of connection and perhaps what

### **Initial Codes**

“thinking about myself and clients, as having had more shared experiences, albeit different”  
“I feel, like the line between therapists and clients has been blurred more now”  
Not putting people in the patient role  
Feeling less separate from clients  
Making changes in how I perceive myself and clients  
Considering similarities between self-clients experiences  
“I feel more like, (small pause) it’s two humans meeting rather than a client and a therapist in those really set roles”  
Considering roles and positions  
Recognising commonalities with clients experiences  
Minimising the difference between client-therapist  
Shattering the us and them thing  
Bulldozing the wall down between us and them  
Having shared similar thoughts to clients in own therapy.  
Feeling less of a difference between client and self  
We are all the same  
Having therapy is not a big deal  
Talking with others about therapy  
Removing stigma by having a personal experience of therapy  
Forgetting that MH is stigmatised  
Thinking about own core difficulties

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Seeing those difficulties in clients  
Going through similar experiences  
“And when you get down to it it’s about relationships; it’s about identity and it’s about anger and it’s about depression and it’s about love and these core core things that are just human and it’s just about humanness.”  
Thinking about clients as human  
Appreciating that there are core things that matter to everyone  
Relationships being the common factor  
Believing there is something inherent in the connection between people  
Having space enables for better connections

**Reconceptualising Mental Health:** it’s not about being mentally ill or not being mentally ill

Memo: 19/12 I am thinking about whether to split this category into two processes – one which is something about feeling less of a distinction between self- client, and then perhaps this then shifts or impacts on how pp see MH more generally ? For pp 004, 005 its seems that there is another process where by they see MH differently as a result of how their thinking about themselves and their clients has happened though experiences in PT. this links with the extract below....

005 “And I guess you know partly through my therapy there was the kind of the realisation and acceptance that it’s not about being mentally ill or not being mentally ill it’s just about something a bit broader about kind of I guess accepting yourself and your past and what’s happened and moving forwards but also knowing that anybody at any point is at risk really of having mental health difficulties and bringing them into contact with services and but then going back out again and I guess some, probably also some of the teaching on the course is kind of some of our lecturers are quite [cough] think that way sort of, it’s not particularly a medical model course it’s..”

and it’s kind of more on a spectrum, (R: Mm) erm, so, I guess thinking about myself and clients, as having had more shared experiences, albeit different, (R: Mm) so I guess having had similar categories of experience but not obviously the same experiences (R: Mm) does that make sense?

### **Focussed Codes**

Considering how I conceptualise mental health  
Changing my perception of mental health  
Seeing emotional distress on a spectrum  
Feeling that distress is a universal phenomena  
Knowing that anyone is at risk of Mental health difficulties  
Anyone can have difficulties  
Realising everyone is vulnerable  
Appreciating life could be very different  
Believing difficulties are on a spectrum  
Recognising aspects of your own emotionality in clients

As can be seen I had number of focussed codes around experience related to learning from being a client. Initially I conceptualised these as a parallel process of learning and applying knowledge and this was my original model:

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Concept: Experiencing being a client

Me as client (category)

Me as therapist (category)

Learning through experiencing



Understanding the clients perspective

Recognising my own vulnerabilities



Feeling connected

Knowing what I valued



Modelling what I've valued



Feeling more empathetic

As I completed more interviews and tested these ideas against the data, I realised that although being in the role of the client, and the subsequent learning is key to participant's experiences, that there are other related experiences and learning that I was not considering alongside these. I also shifted in the wording and in my understanding of the various categories and codes the more interviews I completed. Subtly shifting these, and importantly trying to establish how the different elements of the process seemed to fit together. Much of this happened through drawing out diagrams and copying and pasting quotes from the texts as well as codes and sticking them to the diagrams to try and establish what I felt was happening in the data. This led me to the final version of understanding this concept- which was then discussed in interview 11 and 12 for confirmation – and was confirmed.

## Appendix V: Quality Review Table for current Research

Criteria (Elliot, Fischer & Rennie, 1998)	Evidence for meeting criteria
<p><i>Explicit scientific context and purpose.</i> The manuscript specifies where the study fits within relevant literature and states the intended purposes or questions of the study.</p>	<p>The introduction chapter clearly provided a context for the current research describing how results may contribute to the field. The systematic literature review demonstrated a need for further research in this field. The research question, Rationale, and potential clinical relevance were clearly stated.</p>
<p><i>Appropriate methods.</i> The methods and procedures used are appropriate or responsive to the intended purposes or questions of the study.</p>	<p>The chosen methodology (GT) was considered appropriate for the research as the purpose was to evaluate <b>processes</b> related to how participants may develop via experiences within PT. This methodology would allow for a rich, in-depth exploration of participants' accounts, whilst attending to action and process related to what, why and how question (See chapter 3.2.3).</p>
<p><i>Respect for participants.</i> Informed consent, confidentiality, welfare of the participants, social responsibility, and other ethical principles are fulfilled. Researchers creatively adapt their procedures and reports to respect both their participants' lives, and the complexity and ambiguity of the subject matter.</p>	<p>The Methodology chapter clearly outlines all aspects of the ethical procedure including how informed consent was obtained. Ethical considerations were given and confidentiality was maintained. Participant information sheets, and consent forms can be reviewed within Appendix section 7.2. Potential distress was considered and all participants had a debrief following interviews, which allowed for exploration of any questions or concerns related to the research process. All participants were reminded of their right to withdraw their data at any point during the research process, and the option to terminate the interview at any point.</p>
<p><i>Specification of methods.</i> Authors report all procedures for gathering data, including specific questions posed to participants. Ways of organizing the data and methods of analysis are also specified. This allows readers to see how to conduct a similar study themselves, and to judge for themselves how well the reported study was carried out.</p>	<p>The Methodology chapter illustrates how data was gathered, given specific examples of interview schedules and the development of these, which can be found in the Appendices chapter.</p> <p>The analytic process was well specified in the methodology chapter, with examples of how analytical procedures were followed, and reflection on these. Examples of analytic procedure are included within the Appendices so that the reader can judge for themselves the quality of the analytical procedure.</p>
<p><i>Appropriate discussion.</i> The research data and the understandings derived from them are discussed in terms of their contribution to theory, content, method, and } or practical domains, and are presented in appropriately tentative and</p>	<p>Within the discussion chapter, the research finding are situated within the context of the wider literature, with attention to relevant psychological theory. Strengths and limitation of the current research are outlined, appropriate implications are provided given the nature</p>

<p>contextualized terms, with limitations acknowledged.</p>	<p>of the methodology, and suggestions for future research is considered.</p>
<p><i>Clarity of presentation.</i> The manuscript is well-organized and clearly written, with technical terms defined.</p>	<p>The use of sub-headings has been utilised to assist the clarity of the manuscript. Terms and abbreviations are clearly stated throughout. Every attempt has been made to write clearly, and concisely.</p>
<p><i>Contribution to knowledge.</i> The manuscript contributes to an elaboration of a discipline's body of description and understanding.</p>	<p>The research is considered unique and to have added to the small body of literature related to the use of PT by Clinical Psychology Trainees.</p>
<p>1. <i>Owning one's perspective.</i> Authors specify their theoretical orientations and personal anticipations, both as known in advance and as they became apparent during the research. In developing and communicating their understanding of the phenomenon under study, authors attempt to recognize their values, interests and assumptions and the role these play in the understanding. This disclosure of values and assumptions helps readers to interpret the researchers' data and understanding of them, and to consider possible alternatives.</p>	<p>My epistemological position is discussed throughout the research. My personal relationship to this research is discussed in the introduction, it is reintroduced in the methodology chapter, in which descriptions of measures taken to avoid drawing personal meaning from the data has been provided.</p> <p>I have acknowledged how my own values and assumptions may impact on the research process throughout. A description of my own perspective around my personal experience of PT and how this has related to my own experience and development in PT can be found in the Appendices. It is hoped that this can assist the reader on making their own judgement on the degree to which my own assumptions, values and experiences may have impacted on the research process.</p> <p>During the process I took steps to ensure I was reflecting with both my supervisory team, peers and my therapist in order to bracket my experiences.</p>
<p><i>Situating the sample.</i> Authors describe the research participants and their life circumstances to aid the reader in judging the range of people and situations to which the findings might be relevant.</p>	<p>Adequate information regarding the participants can be found within the Methodology chapter.</p>
<p>3. <i>Grounding in examples.</i> Authors provide examples of the data to illustrate both the analytic procedures used in the study and the understanding developed in the light of them. The examples allow appraisal of the fit between the data and the authors' understanding of them; they also allow readers to conceptualize possible alternative meanings and understandings.</p>	<p>Direct quotes were provided throughout the Results chapter in order to ground my data within the proposed results.</p> <p>An excerpt of an annotated transcript, an example of the development of a key category, as well as examples of model development was provided within the Appendices to assist the reader in appraising the analytic process.</p>

<p><i>Providing credibility checks.</i> Researchers may use any one of several methods for checking the credibility of their categories, themes or accounts. Where relevant, these may include (a) checking these understandings with the original informants or others similar to them; (b) using multiple qualitative analysts, an additional analytic ‘auditor’, or the original analyst for a ‘verification step’ of reviewing the data for discrepancies, overstatements or errors; (c) comparing two or more varied qualitative perspectives, or (d) where appropriate, ‘triangulation’ with external factors (e.g. outcome or recovery) or quantitative data.</p>	<p>A number of methods were employed to ensure credibility. I attended GT workshops in which examples of my own focussed coding was provided, and discussed, alongside considerations of potential alternative codes. The first transcript which was line-by-line coded was double coded with a colleague and comparisons made of the focused codes with discussion around any alternative codes that may have assisted in better understanding the results. I regularly met with my supervisory team to review and reflect upon results.</p> <p>The final model was assessed for credibility and fit with three participants. This shifted the model and adaptations were made to the final model to incorporate the addition of new results.</p>
<p><i>Coherence.</i> The understanding is represented in a way that achieves coherence and integration while preserving nuances in the data. The understanding fits together to form a data-based story} narrative, ‘map’, framework, or underlying structure for the phenomenon or domain.</p>	<p>Within the Results chapter, the core concepts, categories and related categories are described and represented graphically in Model 1 and Model 2 providing a coherent visual understanding of the results.</p> <p>Subheadings are used to ensure coherence for the reader. Direct quotes from participants are provided throughout so nuances are not lost.</p>
<p><i>Accomplishing general vs. specific research tasks.</i> Where a <i>general</i> understanding of a phenomenon is intended, it is based on an appropriate range of instances (informants or situations). Limitations of extending the findings to other contexts and informants are specified. Where understanding a <i>specific</i> instance or case is the goal, it has been studied and described systematically and comprehensively enough to provide the reader a basis for attaining that understanding. Such case studies also address limitations of extending the findings to other instances</p>	<p>The limitations of generalising the findings of the current research are discussed within the final chapter. Consideration is given to the convergence of the data with other research findings adding to the relevance of the finding. Generalizable findings were however, not the aim of this research, which was clearly discussed.</p> <p>The Methodology chapter provides a justification for the number of participants recruited.</p>
<p><i>Resonating with readers.</i> The manuscript stimulates resonance in readers or reviewers, meaning that the material is presented in such a way that readers or reviewers, taking all other guidelines into account, judge it to have represented accurately the subject matter or to have clarified or expanded their appreciation and understanding of it.</p>	<p>It is hoped that the current research has provided the reader with sufficient information to consider the role of PT for training CPs. I have aimed to present the research in a way which I hope has expanded the readers understanding of the topic and provoked thinking around issues related to the training of CPs and potential training methods.</p>

