Intra- and interpersonal factors in the use of personal therapy by trainee clinical psychologists.

Doctoral Thesis

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Abstract:

The purpose of personal therapy for psychologists can be understood as a method of personal and professional development (PPD) and/or in terms of help-seeking. This study aims to consider differences in the use of personal therapy among trainee clinical psychologists. It used a cross-sectional, survey design and invited all British trainees to participate. 437 trainees (25% response rate) completed measures on intrapersonal and interpersonal variables, and answered several factual questions pertaining to demographics and clinically relevant experiences. Several trainees reported experiencing childhood abuse. A large proportion had experienced therapy prior to training. These issues were explored. Discriminant analyses demonstrated that attitude to therapy for PPD and psychological flexibility were important predictors of use of personal therapy, as was emotional neglect in childhood. The potential link between difficult early experience and ability to manage internal experience was considered. Therapeutic orientation of trainee, year of training and course support were also important factors in differentiating between groups. Implications for training and PPD were discussed in terms of suggestions for courses and trainees.

Introduction

Outline of Introduction:

This study aims to consider the use of personal therapy among trainee clinical psychologists (referred to as trainees throughout this study) in the UK in 2010. This chapter aims to provide some insight into relevant literature in the area and discuss how this study could contribute to current knowledge. A literature search was conducted using PsychINFO database, using the search terms “therapy”, and “trainee clinical psychologist”, and subsidiary terms “personal and professional development”, “reflective practice”, and “therapist”. Relevant papers were identified; these suggested further reading.

The literature on the purpose and perceived importance of personal therapy will be discussed in the context of personal and professional development, particularly in terms of reflective practice. Alternative views on therapy’s purpose, notably the need for help among those in training will be explored. A conception of the potential role of experiential avoidance in the view of and use (or non-use) of personal therapy, which has not to date been explicitly elaborated, will be considered throughout. The current understanding about the differences between those who engage with therapy and those who abstain will be discussed, with reference to how this decision may be made, including with relation to interpersonal issues such as attachment. Some limitations in this understanding will be highlighted, and the anticipated contribution of this project to this area will be explained.

The Philosophical Position of Clinical Psychology

Clinical Psychology in the UK adopts a primarily scientist-practitioner model. Shapiro (2002) discussed the changing meaning of this term, describing an

evolution since it's origin in 1947, when it was developed as a model for training psychologists to be both researching scientists and practitioners. In the 21st century, Shapiro (2002, p233) argued that a scientist-practitioner model must integrate "science with practice both conceptually and operationally". This meant conducting clinically realistic research and scientific thought and action in clinical work. This approach is attractive in that it makes experience understandable for large populations. It also aims to protect the public; working on the basis of evidence may prevent the use of ineffective, or potentially harmful, techniques. This model inevitably views clinical psychology as a science, however, this may be open to question when professionals consider their personal view about what their professional role is, or how therapy works. Marzillier (2010) wrote about his sense that scientific psychology had greatly developed the understanding of the mind and brain, but that it could not provide all the answers for working psychotherapeutically with individuals. As Wigg (2009) notes, not all clinical psychologists would view themselves as therapists. David (2006) questioned the feasibility of being a scientist-practitioner, particularly as a trainee, in her reflective account on the challenges of conducting research in the NHS.

In recent years there has been some movement by some in the profession to consider a reflective practitioner model. Advocates of reflective practice have acknowledged that it is difficult to define (Cushway, 2003), nevertheless the work of Schon (1983) is often cited as seminal in understanding what is meant by this term. He suggested that theoretical understanding may inform practice, but was insufficient. Stedmon, Mitchell, Johnstone and Staite (2003) considered reflective practice in terms of a) the use of our own experience (as therapists) of the therapeutic space, considering what we bring to the arena based on our previous life experience, and b) learning by doing. Stedmon and Dallos (2009) defined reflective practice as the process of analysing and reanalysing important events,

using multiple levels of meaning and types of knowledge. This may be done in action, for example during therapy, when a practitioner may notice attentional focus or shift in emotion. Reflexivity is the process by which past reflections are further considered and learned from, for example in supervision. It notes the personhood of the therapist in terms of political views, social status and experiences. Both reflection and reflexion are required for learning (Stedmon and Dallos, 2009).

Reflective practice questions evidence, and guidelines for practice, suggesting that there may be various ways to view the same problem, or to consider whether an experience *is* a problem. The evidence underpinning a guideline may struggle to encompass issues of co-morbidity or complexity within a problem that may not be clearly defined. Stedmon and Dallos (2009) suggest that reflective practice is allied with deconstructing difficulties through formulation, and through this method gaining ideas about how to move forward.

Whitaker (2004) noted that reflective practice can fit with evidence-based practice if, for example, some of the definitions of what constitutes evidence are broadened to include the experience of the clinician. Butler (1998) suggested that formulation is a set of hypotheses, thus showing how a reflective approach could be married with a scientific method. Different therapeutic approaches may take diverse approaches to formulation, depending on the case, with more or less emphasis placed on the therapeutic relationship and how this is informed by the stance of the therapist.

Evidence shows that the therapeutic relationship is central in effecting change (Wampold, 2001), and thus some of the focus of research has shifted from therapeutic techniques and tools to the people within the therapeutic encounter. Reflective practice necessitates consideration of not only what to *do* within the

therapeutic process, but *how* this may impact on the self and the other person/people within the therapeutic relationship (Lavender, 2003). The increased evidence for the importance of therapeutic relationship and issues of reflection demonstrates how the approaches to practice can overlap and inform each other.

There has been an increased recognition of the impact of hearing painful stories on the therapist, and consideration of how emotional responses can be understood and used therapeutically, or not. This can refer to therapeutic use of self (Wosket, 1999). Fonagy, Gyorgy and Jurist (2004) wrote about the development of the self and the internal representation of others as a process of mentalisation. A sensitive, warm and appropriate mother-infant interaction is the crucial element in this process as it enables the infant to gradually develop mental states that differentiate the self from others resulting in a fully developed concept of intersubjectivity. The increasing awareness of mental states in oneself as well as others is referred to as reflective functioning. The latter is facilitated through early experiences of an infant of being regarded and treated by her mother as an individual with her own mind, feelings and desires rather than a baby with needs only. To the extent that a mother is well able to correctly display her infant's mental states – referred to as affect mirroring – infants can attribute meaning to these mental states and can begin with the process of affect regulation using their mothers affective displays as a guide.

There is a need for professionals working therapeutically to be able to monitor and reflect on the self during, and outside of, therapeutic sessions. This must be done in order to gain ideas about what may be happening for the client (transference or counter transference) or to reflect on how they may be directing the work. There is a need to hypothesise with the client about their actions, views, and motivations in order to build formulations which are often the basis for

therapeutic intervention. There are also relational issues to be reflected on, including issues of power and containment. These numerous areas in which skills and competencies must be developed, beg the question whether development as a professional should also consider the self of that professional and, therefore, also consider personal issues. Previous personal experiences and relational patterns may be present in therapeutic relationships for both clients and therapists; it is therefore important to consider how personal life experience is an important feature within professional practice.

Personal and Professional Development (PPD)

Wosket (1999), a therapist, wrote that her development as a professional was defined by her increased use of self, where self was understood as personal characteristics, such as personality and life experience that were used as therapeutic instruments. The ability to access and use these had developed through work focussing on personal growth. These concepts seem ambiguous; Hughes and Youngson (2009) note the lack of clarity in the literature, thus far, about the meanings of terms such as “personal growth”, “personal development” and “professional development”. There is a lack of definition about what these might look like and how achievement could be noticed. It is also unclear whether there are differences between processes of “personal” and “professional” development or whether they are synonymous

Harper (2009) wrote about the “confessional” feel of reflection. Personal vulnerabilities, while human, are by nature areas in which a person may feel relatively weak. Within professional contexts, it may not be desirable to be connected to areas of relative weakness. This may be particularly so in clinical psychology, which is very competitive, in the early stages especially, and associated with helping others. Acknowledgment of similarities between

professional and client may be difficult. Central to an unwillingness to connect with experiences of vulnerability may be the tendency to avoid experiences.

Experiential avoidance (Hayes, Wilson, Gifford, Follette and Strosahl, 1996) is defined as the unwillingness to remain in contact with private experiences. We may try to avoid internal experiences that are understood to be “negative”, including experiences of anger, sadness and vulnerability. It has been suggested that this unwillingness may be related to early experiences of emotional invalidation (Mountford, Constantine, Tomlinson and Waller, 2007). For example, being told not to cry in childhood, does not make a child less sad; it teaches them that crying is not acceptable. They may then learn to remove themselves from contact with internal experiences that might make them cry (Hayes et al, 1996). Similarly to denial, this avoidance may not be wholly accessible to awareness. Very successful avoidance would mean that there would be a lack of awareness that difficult experiences were present at all. Hayes et al (2006) consider that acceptance, rather than avoidance, of experience leads to greater psychological flexibility and a greater likelihood of living one’s life according to one’s values. Similarly, compassion towards one’s self rather than self-criticism (Gilbert, 2005) may be more useful in supporting people to pursue what is meaningful in their lives.

Experiential avoidance may lead therapists to avoid connecting with experiences of vulnerability that may seem similar between themselves and their clients. Hayes et al (1996) wrote about the effect that avoiding emotion has on reducing psychological flexibility and ability to cope, but also on reducing a person’s access to their own wealth of personal knowledge and wisdom. Wosket (1999) wrote that increasing her use of self, including her connection to her internal experiences made her a better practitioner. Issues of experiential avoidance,

which Hayes et al (1996) note as pervasive throughout society, may be relevant in training a person in the use of self.

PPD: what it means and why it matters:

Hughes and Youngson (2009) wrote about the importance of personal development in clinical psychologists. They stated that

> "to be a clinical psychologist is to work in partnership and to work in relation to others. Who we are in relation to others and our community, and our awareness of this, has been highlighted as a major issue in personal development" (Hughes and Youngson, 2009, p41).

This directly commented on increasing awareness and connection to the self of the practitioner as central in development. Hughes and Youngson (2009) suggested a model of the process of personal development leading to personal growth, and the realms of personal development (see Figure 1). The self is seen as embedded in relationships and the community. Understanding about the self may develop in any of the realms, all of which overlap and affect each other. The self at work domain suggests that Hughes and Youngson (2009) consider that the personal and professional may overlap.

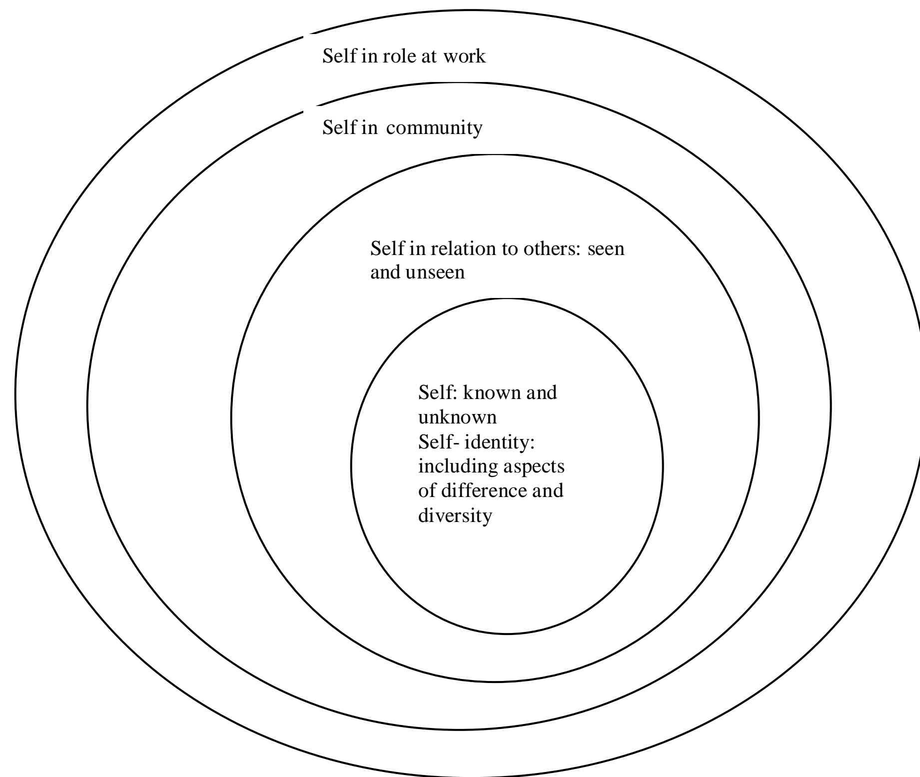

Figure 1: Realms of personal development (Hughes and Youngson, 2009)

There are personal, and human, reasons for the importance of development. Maslow's (1943) hierarchy of needs includes the need for self-actualisation. For those working in helping professions, there is arguably a need to consider personal resilience, improve effectiveness and reduce the risk of harm to self and others. There is also an ethical question about the need to "practice what you preach" (Norcross, Bike, Evans and Schatz 2008), that is, seeking help and developing within one's self.

Alongside these issues are professional imperatives. Development is seen as paramount for clinical psychologists. The Knowledge and Skills Framework (KSF), within which NHS employees are evaluated, requires evidence of personal and professional development. It seems that PPD begins with training. There is perhaps scope to understand more about this process during the early

developmental stage of becoming a Clinical Psychologist. It is perhaps at this stage that conceptual and therapeutic positions, including on science versus reflection and use of self, begin to become more important and internalised. Clinical psychology doctorate courses are required by the British Psychological Society (BPS) and Health Professionals Council (HPC) to demonstrate that they foster personal and professional development in order to be accredited.

Fostering Personal and Professional Development by Training courses

Used by the Newcastle course, Sheikh, Milne and MacGregor (2007) offered a model to facilitate PPD in training clinical psychologists. The article considered the functions of this type of development, and the methods by which this may be achieved. This may include, for example, reflective groups, personal therapy, university sessions and assignments, such as journals. Central within all discussions about PPD is the idea of increased reflection and reflexivity; the ability to think about what is happening around and within oneself and to learn and possibly make changes in one's own behaviour. Courses may position themselves differently on how they view the need for PPD, which may influence how courses seek to accomplish the goal of PPD at a number of levels, outlined below.

- Philosophical Stance

Most courses state they are critical, reflective-scientist practitioners (or some other combination of this stance), in their statements for the Clearing House. It is possible that emphasis may be placed on one or other part of the combination at various times of training and by various members of the course team. This may lead to an increased emphasis on the scientist-practitioner approach at times (for example, in research teaching), or more widely. This may lead to less opportunity to practice reflection. This philosophical stance may influence how trainees approach placements, supervision and cases.

- Therapeutic orientation

The literature seems to suggest that different therapeutic models view the need for exploration and consideration of personal issues in different lights. There are diverse expectations about how this development should be accomplished and what exactly is required. Stedmon and Dallos (2009) wrote that reflective practice is transtheoretical. It is clear, however, that different approaches view the purpose of and foster reflective skills in different ways.

Stedmon and Dallos (2009) noted clear and careful development of reflective skills in psychoanalytic models, through detailed supervision, observation and personal therapy. Psychoanalytic models suggest that the therapist's own psychotherapy is central in their development of self as therapist, and person, viewing the emotional experience of the therapist as very important. Cognitive Behaviour Therapy views PPD as important for skills acquisition and development of skills in building therapeutic alliance (Bennett-Levy, 2005). Socratic questioning, a key CBT technique is noted as a reflective tool, and self-practice and supervision are areas in which therapists may reflect. Emphasis on systemic models in training might consider PPD in terms of reflection on sociocultural issues, such as gender, class or ethnicity, or on issues of power (Vetere and Dallos, 2009). An emphasis on sharing reflections with teams and clients, through reflecting or supervising teams, might allow for discussion of views and expansion of ideas.

- Differences within the course team

All Clinical Psychologists will hold their own philosophical position on reflective practice and therapeutic orientation, which may fit to a greater or lesser extent with the overall course philosophy. The way in which they connect to difficult experiences and lecture on all issues, including PPD and reflective practice, may

have an influence on how trainees come to think about issues. These lecturers may encourage critical discussions about their positions to different extents.

It is possible that the views of module organisers about what is important, influences what is covered and who they invite to speak about issues. The way in which lecturers are chosen may not always lead to the representation of different ideas, which may influence trainee development.

There may also be differences between tutors in how they advise or support trainees in issues relating to PPD; some may support personal therapy, while others may advocate reflective writing, for example. Hierarchy and power issues may influence how trainees assimilate and act on advice.

- Practical issues

For courses, there are different means of facilitating development. For example, PPD groups may be voluntary or mandatory. The size of the group may be different depending on course size and demands, which may make reflection more or less easy. Arrangements for facilitating groups vary. All these issues impact on how trainees perceive their value (Knight, Sperlinger and Maltby, 2010). Personal therapy may attract some funding support or not, and there may be different views on suggesting therapists. Reflective journals may be assessed or not; concerns about anonymity may make a difference to how these are engaged with by trainees.

Trainees' understanding of the meaning attached by the courses on which they train to the methods chosen may impact on how they pursue and engage with development activities. This is likely to lead to differences in uptake of opportunities to practice reflective and reflexive thinking. This in turn may have

implications for the development of what is seen to be a competency in Clinical Psychologists.

Improving Reflective Practice in Trainees

Wigg's (2009) thesis on enhancing reflective practice in trainees considered the debate about the use of personal therapy, and researched the impact of personal development groups on reflective practice. She concluded that these groups can be useful in increasing reflective practise if certain conditions are met, such as nurturing facilitators and a safe space. She noted a process through which reflection may occur and then be acted upon, or not, and considered the effect of group process and dynamics on the effectiveness of this process.

Models of improving reflective practice often include personal therapy. There are those who strongly argue for the importance of personal therapy in the development of reflective skills, and the recognition of the person within the professional. Thomas (2004) suggested that a scientist-practitioner standpoint encourages professionals and trainees to view themselves as free from inner struggles and as distant from the emotional pain of others (namely clients). This idea may sit alongside those about experiential avoidance and willingness to connect with experience of the self and others (Hayes et al, 1996). Thomas (2004) questioned the idea that clinical psychology could be wholly objective or therapy be truly scientific. Thomas (2004) was concerned that training based on core competencies could make it difficult for trainees to be open about feelings of actual or perceived incompetence, which one could argue are a fundamental part of any learning process. This leads to questions about whether the scientist-practitioner approach to clinical psychology, and current training practices, encourage disconnection from and/or avoidance of emotional experience.

Thomas (2004) suggested that personal therapy was also important in learning how to be containing for clients, much as our early experiences of parenting enable us to feel contained (Bion, 1976). She also noted the idea that the experience of being a client allows a different understanding to emerge about the therapeutic relationship.

Norcross (2005) synthesised 25 years of research to argue the utility of personal therapy in training. Throughout his research, 6 common themes emerged in therapist's reports about how personal therapy had been useful to them. These themes were that:

- personal therapy can improve the cognitive and emotional functioning of the practitioner;
- a more complete understanding of personal dynamics, interpersonal issues and conflictual issues was achieved allowing the therapist to manage countertransference dynamics more appropriately;
- personal therapy alleviated emotional stress that had arisen from the work being done by the therapist allowing for a "profound socialisation" experience, whereby therapists could see the potential transformative power of therapy in their own lives and were thus more convinced of its validity as a method for promoting change;
- personal therapy served to sensitise therapists to the clients' position and needs, thus increasing respect and empathy for a client's struggles;
- personal therapy allowed therapists to learn through observing the skills of their own therapist.

He noted that the vast majority of those he had spoken to had found therapy beneficial, and were satisfied with the outcome. Norcross (2005) concluded that training psychologists should aim for the seamless integration of technical

competence *and* personal growth. Consequently, he stated that personal therapy should be integral in training, should be supported by courses and should be presented as a lifelong tool for personal development.

Both Thomas (2004) and Norcross (2005) take a psychodynamic perspective on the necessity of one's own therapy in learning to be a therapist. It is therefore perhaps unsurprising that they seem to be saying that personal therapy is the method of choice for personal development. John Norcross is an American psychologist, and the routes to qualification, and cultural view of therapy is somewhat different in the United States to that in the UK. Clinical training does require personal and professional development, which is closely associated to increased reflective practice. This is advocated by most therapeutic approaches, although the view of personal therapy to achieve this is more equivocal.

Qualification and Use of Personal Therapy:

Personal therapy is not mandatory in the training of clinical psychologists in the UK. The BPS (2010) state this is due to the historical development of clinical psychology from a scientist practitioner base, and the range of service contexts within which clinical psychologists work. They state in the "Frequently Asked Questions" part of their website, that the difference between clinical and counselling psychology (where personal therapy is mandatory) is largely historical and reflects the different roles and functions of each discipline. Counselling psychologists work predominantly as therapists, and thus need to have a space to reflect on therapeutic process. This seems to overlook the fact that, for many clinical psychologists, a therapeutic caseload is a large part of their role.

There is vast debate on the merits and drawbacks of mandatory therapy, and the ethical position of courses insisting on personal therapy, particularly in the

counselling psychology literature. There is debate in the clinical psychology literature about the lack of mandatory personal therapy, and how this fits with the training of professionals to provide psychotherapeutic input. Thomas (2004) and Norcross (2005) have both argued for the importance of personal therapy, and Timms (2007) from the Bristol course tentatively suggested that personal therapy receive more support from training institutions.

Atkinson (2006) has written that mandatory therapy is more congruent with some models than others, dependant on the philosophical position of the therapeutic model. He suggested that if therapy is viewed as a helpful means of resolving difficulties, then therapy for all trainees would assume that all trainees have difficulties to resolve. That assertion could feel like an imposition for some. He argued that there are other ways to learn the necessary skills of therapy and, further, that therapy can carry risk as it may cause harm. Other researchers have noted that therapy has the potential to be harmful (Winter, 1996), however the suggestion that potential harm should be the reason for not making therapy mandatory for those who facilitate it seems interesting. It is unclear why risks of harm may be unacceptable for those training to be therapists, but accepted for clients. Should therapists be exempt from experiencing the distress that clients may feel on the basis of risk of potential harm? This argument can, perhaps, be understood in terms of experiential avoidance and reluctance to connect to distress (Hayes et al, 1996). Personal therapy outcome research (Orlinsky and Howard, 1980) suggests that a valued outcome from therapy is self-relatedness, or being in touch with one's own feelings. It is unclear why Atkinson (2006) might think that this would not be of value to trainees, however if feelings are evaluated as being "negative" or "harmful", then it would make sense to avoid being connected with them.

Atkinson (2006) argued for substantial opportunities for personal development, alongside recognition that this may be achieved in many ways. He argued that other methods, such as reflective groups, may be more congruent with particular therapeutic models. It is noted that Atkinson (2006) did not state which models these might be. As has already been discussed, psychoanalytic models explicitly require personal therapy, and systemic models demand increased reflexivity and awareness of the impact of self. It is therefore possible that Atkinson was referring to CBT, which has self-practice at its core in developing reflective skills, and has a problem-focussed view of the purpose of therapy. This may be an important point in the current climate, where CBT is perhaps seen as the model of choice by NICE and scientist-practitioner approaches. The dominance of CBT means that training will reflect this; this will perhaps also have an impact on the extent of support for personal therapy as a means of developing reflective skills.

The difference in view of personal therapy as developmentally- or specific problem-focussed is thus clear. Studies seem to take an either/or position on the view of the purpose of personal therapy. Holzman, Searight and Hughes, (1996), is perhaps the only study to take a both/and position. Their study indicated that personal therapy could be aimed at both the resolution of personal difficulties and personal/professional development

How often is Personal Therapy actually used?

Prevalence of the use of personal therapy remains difficult to estimate among professionals, primarily because of low response rates in studies examining this. There are inevitably questions about bias in responses, and about the accuracy of estimates. In the United States, Norcross and Guy (2005) wrote about prevalence of personal therapy use by mental health professionals. They noted a prevalence rate across 13 studies of 75%, with a low of 53% for behaviourists and high of 98% for psychoanalysts. They did not note changes in the

prevalence rate over time, and reported that returning to therapy following training was to be expected, with many studies reporting around 50% returning at least once following training. They reported that some studies suggested a slightly higher uptake by women than by men, but could not explain this finding. There was also a higher percentage of married therapists using personal therapy; they suggested that this was not necessarily a function of age, rather that it was a strategy for resolving difficulties that may otherwise have led to the dissolution of the marriage. They noted that divorce and remarriage were often themes in the therapy.

Orlinsky et al (2005) considered prevalence among therapists from European countries, including France, Germany, Russia and Israel, although not the UK. There were difficulties with response rates, and in operationalising the meaning of "psychotherapists" as different countries had different requirements for training and practice, as well as different preferences for therapeutic orientation. They reported that the majority of European psychologists had used personal therapy at least once, with 90% of French, Danish, and Swiss psychologists having used personal therapy. The country reporting the lowest prevalence was Portugal at 66%. Personal growth was the reason cited most frequently for entering personal therapy. There does not seem to be any large scale survey about the prevalence among psychologists in the UK, or on the use of personal therapy among trainee therapists. All these studies suggest increased use of therapy among therapists when compared to the general population; da Silva and Blay (2010) found in their review that most studies showed a prevalence rate of 1-2% in the general population.

The last published review of the role of personal therapy for therapists was by Macran and Shapiro (1998), who discussed the work of researchers, including those working in the 1950s onwards. They noted that there were relatively few

studies; most of these were surveys. They noted more outcome than process studies. Researchers had predominantly focussed on measures of client outcome based on the therapists' use of personal therapy, rather than considering the relationship between the therapists' use of personal therapy and the in-session experience of therapist and client. Studies that had been published often had small sample sizes and unimpressive response rates (between 40 and 50%). There were difficulties with confounding variables; the length of clinical experience of the therapist was often not controlled for. A variety of outcome measures were used, making comparison of findings difficult. Macran and Shapiro (1998) concluded that while therapists who had experienced personal therapy found it valuable, there was no clear evidence that this made them better therapists than those who had not had personal therapy. However, there was evidence that therapy had a positive effect on non-specific therapeutic qualities (such as empathy and warmth). They noted that, particularly for relatively inexperienced practitioners, being in therapy and carrying a caseload could be burdensome, adversely affecting therapeutic skills. They recommended more technically sound research in the area, and suggested that process oriented research might prove more fruitful.

Research on Personal Therapy since 1998

Wigg (2009) updated Macran and Shapiro's (1998) review and found fourteen studies in the intervening years. She considered them in terms of their methodological base; whether they were qualitatively or quantitatively based, and who the participants were. Most studies were process-oriented; eight were qualitative, 6 were survey based. Only three of these studies included trainee therapists, only one included trainee clinical psychologists, all the others studied experienced psychotherapists. One study spoke to training course directors. Many of these studies spoke to those for whom therapy was mandatory. She discussed how themes of increased reflection at different levels were present in

all of the studies. In line with the reflective practice focus of her thesis, she suggested a model within which the findings from the studies on personal therapy could be understood. This is shown in Figure 2.

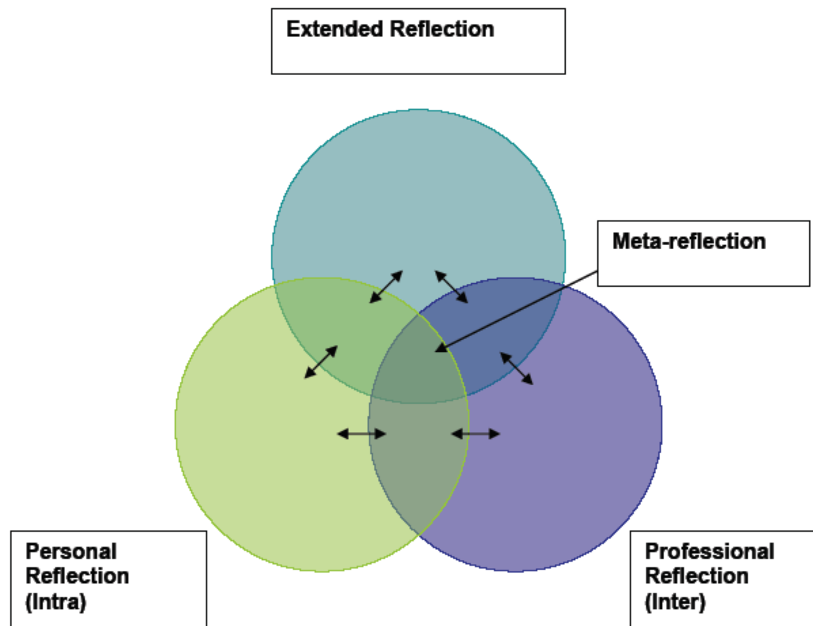

Figure 2: The reflection process within therapists' personal therapy (taken from Wigg, 2009)

Wigg (2009) suggested that each circle represented an area of growth through personal therapy, for example personal reflection (intra) would include a developing understanding of one's own personal difficulties. Where circles overlap, there is thought to be a developing understanding of how the areas interlink; for example, how one's own issues influence how a client's difficulties may be understood (intra and inter). When there is sufficient development in all three areas, Meta-reflection is possible, whereby the therapist is able to hold many reflections at once and work in a more dynamic way. This suggests an

increase in complexity of reflection, however Wigg (2009) does not suggest this is a linear process. Wigg (2009) noted that this was a preliminary model, needing more research. Reflection is noted throughout the literature as being central in PPD; however there may be additional ways in which personal therapy contributes to PPD.

Wigg's (2009) review is an overview of the work undertaken since the Macran and Shapiro (1998) review, and as such does not focus on the views of any specific group. In the last 5 years, there were three published studies which recruited trainees and considered issues of PPD. Gold and Hilsenroth (2009) and Lucock, Hall and Noble (2006) were more focussed on the impact of personal therapy on clinical practice rather than on developmental issues. Two of these studies were not included in Wigg's (2009) review; these were published in 2009 and were therefore perhaps unavailable to Wigg in the preparation of her literature review. It thus seems that study in this area with trainees in therapeutic roles, particularly with trainee clinical psychologists, has been limited in recent years.

Gold and Hilsenroth (2009) studied the effects of clinician's personal therapy on therapeutic alliance in the United States, using questionnaire methodology. The groups were defined by whether or not the therapist had engaged in their own personal therapy and were matched on level of experience. While Gold and Hilsenroth (2009) found no significant differences in terms of service user ratings of alliance, service users whose clinicians had had their own therapy attended more often and for longer. Clinicians who had attended personal therapy reported significantly higher levels of confidence for themselves and the client, with higher scores overall for therapeutic alliance. Gold and Hilsenroth (2009) understood this in terms of personal therapy providing clinicians with increased ability to facilitate empathic relationships, and giving them confidence in therapy

as a means of promoting change (supported by Norcross, 2005). Their results led them to argue that personal therapy was beneficial for novice therapists.

Lucock et al (2006) surveyed the influences on clinical practice as perceived by 95 qualified psychotherapists and 69 trainee psychotherapists in the UK. They found there were differences in the influences depending on orientation and experience of the therapist. Personal therapy was listed as influential by psychoanalytic, psychodynamic person-centred and eclectic therapists, but not by CBT therapists. Qualified therapists were more likely than trainee therapists to cite personal therapy as influential for their clinical practice. The impact of the therapeutic orientation of the therapist was considered very important by researchers; few CBT therapists had engaged with personal therapy (the researchers noted that it was not mandatory, whereas other therapeutic orientations did require it for registration with a professional body).

Mollera, Timms and Allovic (2009) conducted a qualitative thematic analysis with trainee therapists; these were completing counselling diplomas (N=13), counselling psychology doctorates (N=13) and clinical psychology doctorates (N=11). They were all in the first two months of training. Mollera et al (2009) noted that there was a lack of research into what trainees thought of therapy at the beginning of their training. They noted two main themes. The first was "personal therapy helps me to be a better practitioner", which covered experiential learning, personal growth and development, protecting clients in therapy and protecting and supporting the self and learning. These ideas may link to psychological flexibility, self-care and compassion. The second theme was "personal therapy costs me". This considered financial implications, the idea of "opening a can of worms", and personal therapy making it more difficult to participate in the course. These ideas seemed closer to experiential avoidance;

the idea that painful feelings would be disabling and might therefore be best avoided.

Mollera et al (2009) noted that participants were more interested in professional than in personal development, as compared to qualified professionals from other studies. They also noted strong individual differences on their views about the role of personal therapy. The researchers noted a similarity in responses about the potential value and difficulties offered by personal therapy, which reflected the theoretical literature and responses by qualified therapists. The study had the common difficulties associated with response rate and self-selecting bias in those who responded, alongside researchers who were known as trainers (which may have led to social desirability playing a part in responses). Whilst this is the first study which directly asked trainees about their views, there remain questions about whether this view changes throughout the experience of training. The first year of training is noted to be a challenging time; the lack of follow up data makes it difficult to know how much the timing of the research was an issue. Only using one training course also leads to questions about generaliseability to trainees nationally.

Macran and Shapiro (1998) and Wigg (2009) and in the partial review by Norcross (2005) seem to take a specific position in terms of understanding the merits of personal therapy. All three consider personal therapy in terms of personal and professional development. There are, however, studies, which consider seeking personal therapy during training, or in qualified working life as a form of help-seeking behaviour. Numerous studies have discussed “the wounded healer”; many of these focus on help-seeking behaviour by mental health professionals at times of acute distress or stress. Researchers note that psychotherapists are vulnerable to distress and burnout (Kumary and Baker, 2008). Training is widely acknowledged to be a stressful undertaking (Cushway

1992), and there are studies on trainee use of personal therapy that take this perspective.

Personal Therapy in Training as Help-seeking.

Cushway (1992) completed a study with trainees, in which she found that 59% experienced high levels of psychological distress. A large proportion (75%) reported that they had felt moderately or very stressed as a result of training, particularly during the second and third years of study. There are a number of stressors that are linked with training. The life events that occur during the course may include moving house, and will certainly include frequent changes of placement and constant evaluation. There may be difficulties in negotiating with supervisors, difficult cases, and a high volume to be learned.

It has been considered by researchers, including Kuyken, Peters, Power and Lavender (1998, 2003), that psychological adaptation to the stressors during this period was predicted by coping style, and appraisal of threat. This in turn impacts on a trainees' ability to use the social support available and to engage with training in a functional way.

Dearing, Maddux and Price Tangney (2005) completed a survey-based study on the variables that predict help-seeking (or not) in clinical and counselling psychology graduate students in the United States. They gained useable responses from 262 participants (response rate 27%) on issues relating to their attitudes to help-seeking, and the perceived attitude of the course team towards therapy. They also asked about obstacles to help-seeking and various demographic issues, including those relating to their stage of training. They found that issues of confidentiality, general attitudes towards therapy, and perceptions of the importance of therapy for professional development were the most important predictors of help-seeking. Issues of cost and time were also

considered obstacles. The researchers defined the study in terms of help-seeking, despite the finding that many participants were interested in development. It is unclear whether this is a useful distinction to make; the views of participants on whether they were seeking help for problems or help to develop were not explored. It is perhaps interesting in the context of the understanding that people who are "helpers" may struggle to accept the parts of themselves that may need help.

Jones (2009) considered the help-seeking behaviour of trainees, through exploration of the difficulties they encountered and how they were seeking help at that time. Eleven trainees, in their second year of training, participated. They noted concerns around issues of work-life balance most frequently, with academic and placement difficulties also cited frequently. Other life events, such as moving home, bereavement, health and relationship difficulties were also cited. Help was sought from other trainees on the course, other friends and partners, and less often from the course team. Personal therapy was very rarely sought, and the use of this method of support was not discussed in the results section. While this study has noted methodological limitations, particularly in terms of the number and diversity of participants and potential experimenter bias, it was the only study of British trainee help-seeking in recent years.

Holzman et al (1996), taking a both/and position in terms of help-seeking and development, was perhaps the first study on the views of graduate students. They completed an exploratory survey with 1018 students on American Psychological Association certified Clinical Psychology programs. They aimed to discover trainee views about, and experience of, personal therapy. The response rate was approximately 50%, with 75% of respondents having engaged in personal therapy. This was for a wide variety of reasons, including personal growth, depression, family issues, relationship problems, abuse, and professional

development. Students who had not engaged in personal therapy most frequently said that they did not need it. Financial concerns were cited, as were concerns about confidentiality and a lack of time. Some said that it had never been recommended. Holzman et al (1996) showed that the level of importance placed on personal therapy in terms of improving practice differed by therapeutic orientation, as did thoughts about management of countertransference. The study led to some of the first recommendations for providers of therapy for trainees. It's approach illustrated how seeking help for specific problems which caused psychological distress, may sit alongside or be intertwined with a desire to develop professionally and personally.

The Non-use of Personal Therapy

All the studies discussed demonstrate that there are a number of trainees (and qualified therapists) who choose not to engage with personal therapy. A number of reasons for this have been expressed in the research, including financial concerns and time pressures. Clinical psychology training in the UK is, at the present time, the only funded route to a professional doctorate in psychology (Educational Psychology funded places have recently been withdrawn), and also attracts a liveable salary. Other Psychology training programmes (notably the Counselling Psychology doctorate) are not funded; trainees must find suitable placements in which to gain clinical hours, and pay for their own mandatory therapy. There is also time allocated to study on the Clinical Psychology doctorate, so there are inevitably questions about whether there are concerns other than cost and time that form the basis for non-engagement with therapy.

Studies have spoken about concerns about "opening a can of worms" (Mollera et al, 2009), and about burden on inexperienced clinicians of trying to learn skills, support others in their distress and manage their own difficulties (Macran and Shapiro, 1998). The idea seems to be that, alongside training being a stressful

undertaking, the admission that support may be needed may also be felt as stressful or threatening. This is noted to connect with ideas about experiential avoidance; being in contact with less valued parts of the self may lead to discomfort. Avoidance may occur when this discomfort cannot be tolerated.

The Impact of Others

Vogel, Wade and Hackler (2007) spoke about the effect of stigma on the willingness to seek help. They found that the social stigma attached to being "unwell" and needing counselling was mediated by the self-stigmatising beliefs. They argued that these beliefs came from their culture, and in turn influenced an individual's attitudes to counselling and their willingness to seek help. Thus, inter-personal factors (cultural views) influenced intra-personal development, in this case of beliefs and attitudes. These issues, related to shame and self-criticism, may make it difficult for people to connect with ideas about the self as needing support, or to engage with "help". It would also make a compassionate view of the self more difficult.

Vogel et al's (2007) study was with American psychology undergraduates; however it raises issues about how cultural- and self-stigma influence how people think about the use of personal therapy. It remains unclear how cultural attitudes influence the ideas of trainees about the value and purpose of personal therapy. How this applies to them as facilitators of and/or participants in therapy is uncertain. Stigma and negative ramifications of entering therapy were raised as possible barriers to therapy in Holzman et al's (1996) study, and by Farber (2000), in her investigation of trainee attitudes to personal therapy.

Interpersonal issues may impact on choices, both via a cultural view of the meaning of therapy and via learned styles of relating to others, and expectations about relationships, which may come from history of attachment experiences

(Fraley & Shaver, 2000). Attachment can be understood as the bond between a child and primary care-giver; there are several styles described by the work of Bowlby (1990) and Ainsworth (1978) among many others. This bond can be understood as forming a template for future relationships (Levitt, 1991); where there is abuse and/or sustained invalidation in childhood, there may be long-term interpersonal difficulties.

Numerous studies (Levitt, 1991, Bowlby, 1990) have shown that experiences relating to attachment have long-term effects in terms of how a person may be able to trust others to meet emotional needs, (Hildyard and Wolfe, 2002), be emotionally intimate with others and to be able to mentalise about the needs of others (Fonagy, Gyorgy and Jurist, 2004). Mikulincer, Shaver and Pereg (2003) also suggested that these patterns may be related to coping styles and stress management. It is also noted that attachment and experiential avoidance may be linked, although research in this area is limited. People who have difficult attachment histories are often noted to struggle with affect regulation (Carlson and Sroufe, 1995; Sroufe, 1996). Avoiding unpleasant feelings, or becoming overwhelmed by them, are noted as signals of limited psychological flexibility. All these issues may be relevant in the work of a therapist, and in the decision-making process about the use of personal therapy.

Norcross et al (2008) completed the only study to focus on qualified therapists (some of whom were psychologists) who had never engaged with personal therapy. One hundred and nineteen American participants were asked about their views on personal therapy, the reasons why they had never engaged with therapy, and the circumstances within which they might conceive of themselves entering therapy. They found that, compared to therapy-seekers, non-therapy seekers placed significantly less value on personal therapy as a means of PPD, and did not see it as a prerequisite for training (although interestingly, did not

disagree with either premise – mean scores suggested neutrality in these areas). Reasons for never having entered therapy were largely cited as interpersonal; most commonly dealing with stress in other ways and receiving sufficient support from family, friends and co-workers. This may relate to issues of attachment and experiential avoidance; the ability to engage with others in a way that feels beneficial. Issues about knowing all therapists in the area, confidentiality and issues related to beliefs about therapy were raised. The most frequently suggested reason for considering therapy in future related to the theme of personal and/or professional dysfunction. Stigma was not seen as a primary reason for not entering therapy in this study; a sense of the sufficiency of one's resources (including those that come from others) was considered more important. The issues of stigma, social support and questions about professional competency may be relevant for psychologists to different extents throughout their careers.

The Decision making process: To use or not to use Personal therapy

In her project, Jones (2009) discussed the process through which trainees accessed support. She saw this as a series of decisions, the first of which was whether or not to seek help. Trainees in her study spoke about finding it personally difficult to seek help, due to feelings of vulnerability and exposure. This is perhaps unsurprising given previously raised ideas about willingness to connect with weakness (Hayes et al, 1996; Harper, 2009). There was also a lack of clarity about whether personal issues were up for discussion with course team members. The second decision considered whether to seek help from internal or external sources. Personal therapy was not given any funding support, but a trainee spoke about the need for better signposting of this as an option and clarity about the course view of this option. This gives the sense that it may be difficult to seek therapy when the view of significant others is unclear. This idea is supported by the work of Dearing et al (2005) who found that perceived positive

faculty opinion of students in therapy was related to higher incidence of help-seeking.

Jones (2009) found that external support, such as personal therapy or a mentor was seen as preferable to internal resources by trainees at Leeds, because of the role of the course team in assessing the competence of trainees. This made external resources appear more objective and non-judgemental. The other decisions regarded interpersonal issues; seeking help from staff/supervisors or from peers, and considering whether to seek help from someone whose role matched their problem or someone with whom they had an existing relationship. Perhaps relational issues about safety play a role in these decisions; the ambiguity in course team members' views and their dual role as support and evaluators makes the relationship less than straightforward.

Bryant (2008) completed her thesis on the processes which influence whether qualified clinical psychologists seek personal therapy. She did not distinguish between help-seeking and PPD. Her aims were to consider the influence of personal and professional processes (separately and in interaction with each other) on the decision to seek therapy. She used grounded theory following interviews with 12 qualified clinical psychologists. Eight of the participants had engaged with personal therapy at least once; all of these had had experience of psychodynamic psychotherapy. The remaining four participants had never engaged with personal therapy. From their interviews, Bryant (2008) was able to elaborate four categories which seemed to interact to increase or decrease the likelihood of a person entering personal therapy. From this she was able to suggest a preliminary model (Figure 3).

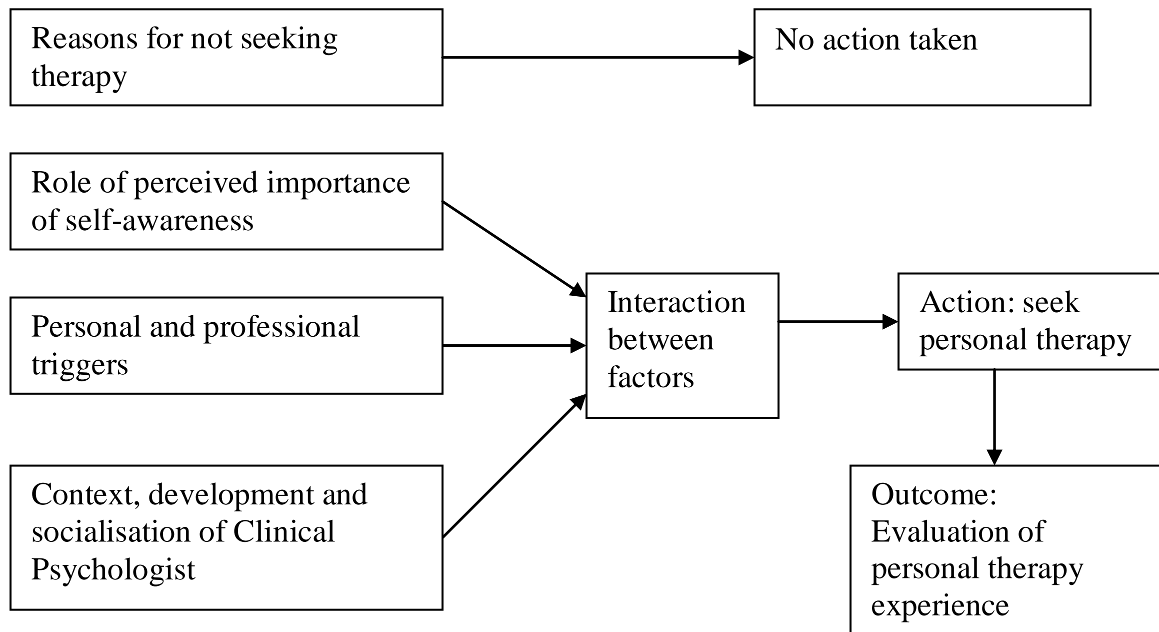

Figure 3: Bryant's (2008) preliminary model of the decision-making process: What influences a Clinical Psychologist's decision to enter personal therapy?

Those who did not seek personal therapy suggested that this was because they had never had a problem serious enough to warrant therapy, their needs were met in other ways, such as self-help techniques, talking to partners and supervision. They said that they were discouraged by practical difficulties or because they feared therapy might be shaming or stigmatising. Bryant (2008) discussed the idea of defensive denial; the idea that some psychologists might need to maintain an "illusion of mental health" and for this reason deny, or avoid connecting with, having difficulties. This concept may sit alongside ideas about experiential avoidance. As can be seen in Figure 3, this led them to take no action in seeking personal therapy. It is unclear whether Bryant (2008) meant that not seeking therapy was a passive non-engagement with an option, or whether it was an assertive choice to not do something.

Bryant (2008) suggested that while the categories interact in a complex way, some issues, such as the fear of shame might be enough to prevent people

seeking therapy. Of the three interacting categories, Bryant (2008) suggested the most important was context, development and socialisation of clinical psychologists. This included learning how to behave like a clinical psychologist, and particularly the view of therapy as expounded by the therapeutic orientation with which a person most closely associated. There was also a suggestion that psychologists are socialised to find it difficult to accept help. The themes raised within this category by participants were around recognising and accepting help (and the difficulties doing this because of the perceived view of psychologists as survivors), the role of perceived stigma in seeking personal therapy, the view of the therapeutic model to which they subscribe of personal therapy, previous positive experiences of therapy, and the influence of significant others, in this case the course on which they trained. Bryant (2008) noted the internalisation of culture into a person's beliefs about therapy, and the effect this might have on seeking therapy.

Perceptions of the importance of self-awareness contributed to the decision to seek personal therapy. This included the belief that self-awareness was vital in becoming an effective clinical psychologist, and beliefs that therapy should be strongly recommended, if not mandatory.

Personal and professional triggers, in Bryant's (2008) model, are a contributory influence that interacts with other influential beliefs and contextual factors. These triggers included an inability to use the usual support systems, because of the need for a different kind of feedback or a sense that what could be shared with significant others was limited. Other triggers included feelings of incompetence, or a need to resolve early/current life experiences which were considered to be impacting on the professional's capacity to fulfil their work role. Bryant (2008) noted the interaction between the desire for professional and for personal growth in this category.

Bryant's (2008) model, while a useful starting point, does not suggest which factors might be most important in the interaction or clarify the differences between the personal and professional. There remains uncertainty about the connection between these two entities; whether they can be separate or whether the personal resides within the professional (Gillmer and Marckus, 2003). The model aims to explain an individual's decision, and as such touches on underlying intra- and inter-personal processes. It does not, however, explore the extent to which these factors impact on decisions to use personal therapy. Nor does it provide answers about the differences between individual psychologists in terms of these processes and subsequent use of personal therapy. As Bryant's project focussed on qualified clinical psychologists, it is unclear what impact stage of career might have, or whether this model applies equally to those still in training.

Limitations of the research

The research on trainees is relatively limited, which is unfortunate given that this is a specific and formative stage of a Clinical Psychologist's career. It is perhaps important to understand what factors impact on a trainee's ability to develop clinical competence, and how individual differences in combination with external influences make it possible for trainees to maximise opportunities for development.

There is little large scale research with trainees. There is a lack of study into their views, and experience, of the process of the development of a personal and professional self. Where small samples are used, there is a risk that generalising findings assumes homogeneity in a group where this might not exist. Diversity remains a topic for discussion amongst recruiters of trainees, however it is clear that trainees come from, and train in, different parts of the country, and may have

a variety of backgrounds and associated beliefs. It is therefore risky to generalise the views of a small number of trainees from one course, or one part of the country, particularly where self-selection biases are also at play.

There seems to be a lack of current information about the use of personal therapy among British trainees, including the prevalence of use and the difference between those who do and do not choose to use personal therapy. There is a lack of understanding about how British trainees use personal therapy in relation to issues that may affect their training and clinical style. These issues may include intrapersonal factors, such as psychological flexibility and coping style and the impact of interpersonal factors, including the impact of perceptions about the beliefs of others about mental health and therapy. Issues of experiential avoidance or defensive denial may also be involved in the non-use of therapy. These issues must be considered in terms of implications for development; all trainees are required to demonstrate reflective and reflexive skills.

Literature on personal therapy use by trainees has largely been completed in the United States to date. It also focuses on problems that require help, or the impact seen in the trainees' clinical work. There has been little consideration of the differences in intrapersonal style between trainees; particularly in terms of self-compassion, coping, and attitudes towards therapy. These issues may have implications for clinical practice, in terms of understanding the self as a practitioner, and issues of self-care, resilience and burnout.

There is also a very narrow view of interpersonal issues, with studies focussing on course attitude and mentioning stigma. There is no consideration, however, of a trainee's life outside or before the course, which may have influenced attitudes, perceptions and actions, including via attachment and early relationships. Given

that cultural beliefs and norms are internalised into individuals via their early experiences within their family, it is surprising that no research has considered the impact of these relationships on a trainee's later choices, either in terms of conflicting or coinciding views. It remains unclear whether conflicting beliefs about therapy, which may come from important relationships outside of the course, could have an impact on whether a person pursues personal therapy.

Aim of this Study

This study aims to find out about personal therapy use among trainees, in particular intra- and interpersonal factors that are related to use or non-use. This study will view the decision to enter therapy in terms of a process, much like the stages of change (Prochaska and DiClemente, 1994), whereby people may be at the pre-contemplation, contemplation, action or maintenance stage. Groups (referred to as PT groups) will therefore be defined as not considering therapy, actively considering therapy, in therapy or recently ended.

Aim of the Study:

This study aims to consider salient discriminators between personal therapy groups (PT groups) of trainees, particularly in terms of intra- and interpersonal factors, including experiences of abuse in childhood. Exploration of trainees' positions in groups in terms of their responses about intra- and interpersonal factors, may allow us to gain an understanding about which factors are most important in the use of personal therapy.

The study will therefore consider intrapersonal factors in terms of coping, attitude towards therapy, psychological flexibility/avoidance, self-compassion and self-stigma. These factors will have developed through interpersonal experiences in childhood and throughout life. Interpersonal factors may thus influence a person's world view indirectly through developmental processes or directly in the present time. The interpersonal factors considered in this study will be the

attitudes of the course and immediate family (namely parents) towards help seeking, perceived social stigma from the wider culture and difficult or traumatic experiences in childhood (namely abuse). Trainee therapeutic orientation and fit between perceived course orientation and participant orientation will also be considered.

These factors can be considered in terms of two themes; Psychological flexibility versus Avoidance, and Self-Criticism versus Self-Compassion. These are linked with flexibility and resilience (Hayes et al, 2006) both of which are important in terms of being open to development and managing difficult life experiences. This is clearly of interest to clinical psychologists and trainees.

Hypothesis:

This study aims to identify the most important personality factors or attributes influencing the decision to undertake personal therapy. It is expected that those in therapy will show more self-compassion and more psychological flexibility than those not considering therapy. It is noted that these factors may not be the most important in distinguishing between those who do and do not use personal therapy.

Method:

Design:

This study used a non-experimental, cross-sectional design to investigate the impact of study variables, namely selected intrapersonal and interpersonal factors, on the use of personal therapy by trainee clinical psychologists. While a cross-sectional design does not allow for inferences about causal links, it has the advantage of one data collection point, which negates longitudinal difficulties with participant drop-out over time. It is also time and cost-efficient.

It was considered that web-based survey methodology would be the most efficient method of data collection. This low-cost and user-friendly format was considered to increase access to the target population.

Participants

Target Population

There are 29 courses located throughout the British Isles. Two courses are in Scotland, there are 2 in Wales, 8 in London and the South East, 7 throughout the Midlands and Central England, 3 in the South and South West and the remainder are located throughout the North of England. There are approximately 1800 trainee clinical psychologists in the UK at any one time. It is difficult to be more precise due to the availability of part-time study in Scotland, and no central information on the numbers of trainees who go on maternity leave or extend training for other reasons. While training courses generally run from October to October, the HPC records registrations by calendar year. The Clearing House shows how many trainee places are available in each year. There is no central body that records the total number of trainee clinical psychologists in the UK.

The Trainee Clinical Psychologist population in the UK is noted as being predominantly white-British, female and middle class. The Clearing House

currently (February 2011) states that they “welcome applications from people from ethnic minority backgrounds, people with disabilities and men as these groups are currently under-represented in the profession”. All trainees will have completed a first degree, usually in Psychology (although some may have completed a conversion course). Many trainees have also completed postgraduate study.

Response rate and Sample

All training courses in the UK were approached about the study with a view to potentially accessing all of the trainees on each course (letters in Appendix B). There were no inclusion or exclusion criteria in this study, although it is noted that the trainee population is a highly selected group, which represents a very small portion of the wider population. One course declined to pass information onto trainees, the remaining 28 consented. This gave a total available population of approximately 1730, assuming that information was passed on.

Trainees were not asked to state the course on which they trained, as it was considered that this would allow a more frank report of the perceived support for therapy and how well course therapeutic orientation matched with their own. This also ensured confidentiality of responses more effectively, particularly for smaller courses. It is noted that 47 trainees requested a report of the results to be sent to them following the completion of the study to university email addresses. From this it could be seen that at least 16 courses (55%) were represented.

466 surveys were submitted into the website. This is a response rate of approximately 27% of the available population. 29 surveys (6%) were removed from the data set due to a lack of consent, or completely blank surveys being submitted. This may have been due to participants checking the survey before completion, or deciding after consenting that they did not wish to answer

questions. The total sample size for this study was therefore 437; this represents approximately 25% of the available British trainee population.

Attrition rates were explored. As the survey only included one compulsory question (the grouping criterion), it was possible for trainees to miss out specific questions or questionnaires. This was considered particularly important in the case of parental measures as trainees may have grown up in single parent families. This was also protective in the case that trainees did not wish to disclose abuse experiences. Seventeen participants dropped out of the study after the initial demographic questions, and thus did not complete any of the standardised measures. This represents a loss of 4% of the sample.

The first 5 questionnaires all related to intrapersonal factors; the remaining 6 questionnaires related to interpersonal issues, including difficult childhood experiences. 78.5% (n = 343) of the sample completed all of the intrapersonal questionnaires. 6% (n = 27) stopped answering questions at some point during the intrapersonal section of the survey, indicating that 67 trainees (15%) chose to answer specific questions and not others.

302 trainees (69%) answered all questionnaires pertaining to interpersonal factors. 10% (n = 45) did not answer any of the questions in this part of the survey. It seems that through this part of the survey, participants were more likely to pick specific questions to answer or not, rather than stop answering altogether. 78 trainees missed out one or two questions; 54 (69%) of these missing responses were regarding the attitude of, and/or invalidating experiences from, a parent. 53 trainees (12%) did not answer any questions about childhood abuse. It seems that a further 27 trainees (6%) answered some abuse questions and not others. The impact of missing data and how this was managed is discussed with reference to the discriminant analysis.

As expected, participants were mostly female (87%), and in their late twenties and early thirties (63%). The spread among year groups was fairly even. The initial aim of the study is to answer questions about demographics and past experiences among this trainee cohort. This fuller description of trainees' view of themselves is in the Results section (p.56).

Measures

The survey began with gathering information on demographics (gender, age, marital status, therapeutic orientation) and perceptions of the course on which they trained, although courses were not identified. This was similar in format to Dearing et al's (2005) work, in which trainees were asked about how the course supported the use of personal therapy. Dearing et al's (2005) ideas were extended in this survey to consider the therapeutic/theoretical orientation of the course and whether the trainees felt that their therapeutic orientation was a good fit with the dominant course positions.

Nine standardised measures followed these questions, in the order below. All measures can be found in Appendix C.

The Brief COPE

The Brief COPE (Carver, 1997) was adapted from the COPE (Carver, 1989), due to its length and redundancy in some items. It measures coping style through likert-style agreement with 28 statements in which trainees rate how often they use particular strategies (4 points from "I never do this" to "I do this a lot"). These statements lead to scores across 14 subscales. These subscales include self-distraction, denial, and substance use and positive reframing. Coping was scored in terms of avoidant or non-avoidant coping (Karekla et al, 2011). Avoidant coping was derived as the mean score from self-distraction, denial,

emotional support, behavioural disengagement, venting, and self-blame subscales. Non-avoidant coping was the mean of acceptance and positive reframing subscales.

The Brief COPE was validated with a sample of 168 people following a hurricane. The internal structure of the scale was assessed through factor analysis and reliability analysis. The factor analysis demonstrated a structure similar to the original scale; items loaded onto nine factors. Reliability analysis showed that all subscales met or exceeded the value regarded as minimally acceptable ($\alpha = 0.5$) (Nunnally, 1978). Reliability scores for subscales ranged from 0.5 – 0.9.

Acceptance and Action Questionnaire –II (AAQ-II)

The Acceptance and Action Questionnaire –II (Bond et al, in press) measures experiential avoidance and psychological inflexibility. This is a revised version of the Acceptance and Action Questionnaire – I, with improved psychometric properties (Bond et al, in press). The AAQ-II was reduced to a two-factor, 10 item scale, and then to a seven item, one-factor scale. It was considered that the three items loading onto the second factor did not significantly add to the scale and were removed. Both versions use a seven point likert-scale response, which requires respondents to say how often statements are true, ranging from "never" to "always". Test-retest reliability of the AAQ-II over three months was 0.81. Internal consistency was α=0.84 across six studies with 2816 participants.

The 10 item questionnaire was used in this study. Bond et al (in press) note that the 10 item version is not significantly weaker in predictive validity. The two versions correlate strongly ($r = 0.97$), so "it should not be assumed that studies conducted with the ten item version are invalid" (Bond et al, in press, p13 of article). An aggregate score was used in analysis.

Self-compassion scale (SCS)

The Self-compassion scale (Neff, 2003) measures compassion towards self, with the idea being that care for self is equated to compassion, as opposed to a critical and harsh stance towards self. It has 26 statements on how people behave towards themselves. Respondents say how often the statement is true for them using a 5 point scale ranging from “almost always” to “almost never”, though intermediate points are not defined.

The scale was validated by a subject pool of 391 American educational psychology students. Sex differences have been shown in this scale; women are generally found to be less self-compassionate than men ($F_{(1, 389)} = 10.83$, $p<.001$). A mean score was used in analysis, as suggested by Neff (2005).

Construct validity was demonstrated through Pearson’s correlations with other similar and different measures. For example, SCS was positively correlated with the self-connectedness scale ($r = 0.41$, $p<0.01$), and negatively correlated with the self-criticism subscale on the Depressive Experiences Questionnaire ($r = -0.65$, $p< 0.01$). Psychometric study of the scale also demonstrated discriminant validity; self-compassion was correlated with self-esteem (Rosenberg, 1965), ($r = 0.59$), although this correlation was low enough to be considered as measuring a different construct.

This scale was shown to have 6 inter-correlated factors (self-kindness, self judgement, common humanity, isolation, mindfulness and over-identified), with one higher order factor (self-compassion). Internal consistency was shown to be 0.92. The scale was found to have good test-retest reliability across all scales correlations ranged from $r = 0.8$ to $r = 0.93$.

Trainee Attitude Towards Seeking Therapy Scale

Trainee attitude towards seeking therapy scale (Farber, 2000), which recognised that trainees would have a different position to therapy from laypersons due to their training and experience. This 22 item measure uses five-point likert scale requiring respondents to agree with statements. Responses range from "strongly agree" to "strongly disagree".

The scale was validated with 275 American students training to provide therapy. It showed correlation between attitudes and action of seeking therapy or not doing so ($r = 0.52$, $p<0.005$), and correlated with the Fischer and Farina (1995) scale of attitudes to help seeking in the general population ($r = 0.65$, $p<0.005$).

Attitudes were shown to have a four-factor structure; professional growth/effectiveness, concerns about credibility, concerns about confidentiality and the need for self-sufficiency. The 22 items in the scale load onto these four factors with loadings ranging from 0.5 – 0.81. Internal consistency for the whole scale was high (α=0.86); internal consistency for the scales was between 0.71 and 0.87, with larger scales showing more reliability.

Self-Stigma of Seeking Help

Vogel, Wade and Haake's (2006) 10 item, uni-dimensional questionnaire on self-stigmatising beliefs associated with seeking psychological help. It uses a five-point likert scale requiring respondents to agree with statements. Responses range from "strongly agree" to "strongly disagree".

This was designed and validated with 583 American undergraduate college students, who were studying undisclosed subjects. It was not stated that any of these were in professional training to be therapists. Internal consistency of the

scale was 0.91. All items loaded onto the single factor (0.54 – 0.84). Test re-test validity over two months was 0.72 (N=226).

Content validity was checked by professional counsellors. Construct validity was demonstrated through study with 470 students, which showed a negative correlation with Fischer and Farina's (1995) Attitude scale ($r = -0.063$, $p<0.001$). They also showed through a negative correlation with the Intent to seek Counselling Scale ($r = -0.38$, $p<0.001$), and through regression analysis, which investigated self-stigma as a unique predictor of seeking therapy ($F_{4,439} = 26.6$, $p<0.001$) that the Self-Stigma scale had predictive validity.

Perceptions of Stigmatisation by Others for Seeking Help

Social stigma associated with seeking psychological help was measured using Vogel, Wade and Asheman's (2009) scale. This scale asks respondents to rate the degree to which others would stigmatise them using a five-point likert scale. Possible responses range from "not at all" to "a great deal".

It was validated across 5 samples of University students, including one sample where participants met criteria for clinical problems. While it is unclear whether different students were in each group, the sample sizes were large (N=130 - 982). Internal consistency was found to be 0.89 for the five items, which loaded onto one factor at above 0.76. This was not significantly different between students from different ethnic groups. Test-retest reliability indicated that the scale was stable over 3 weeks ($r=0.77$, $p<0.001$). The scale was negatively correlated with attitudes to therapy ($r=-0.66$, $p<0.001$), suggesting validity.

In this study, participants were asked about their perceptions of the attitude of the cultural group with which they identified towards them seeking therapy. This was a slight variation on Vogel et al's (2009) study which asked participants to think

about the reactions of those with whom they interacted. Following this questionnaire, participants were asked to identify the cultural, religious and socio-economic groups with which they identified. These were open questions, in which the participants wrote the groups to which they felt they belonged. This was done in order to support participants in defining themselves in words which they considered to be most appropriate.

Attitudes Toward Seeking Professional Psychological Help

This 10 item, uni-dimensional scale was adapted by Fischer and Farina (1995) from a longer scale (Fischer and Turner, 1970) in order to provide a quicker measure of attitudes towards seeking help. It uses self-report five-point likert scale responses to statements; responses range from "agree" to "disagree". Internal consistency was $\alpha=0.84$, all items loaded onto the single factor at an acceptable level (>0.5). Test-retest reliability over one month was $\alpha=0.8$ (N=32). This scale is widely used by other studies in their testing of psychometric properties of measures (see Farber, 2000; Vogel et al, 2009), and by studies of therapy use (Holzman et al, 1996; Dearing et al, 2005).

This questionnaire on attitude towards therapy (Fischer and Farina, 1995) was used to ask trainees how they perceived their parents' attitudes towards therapy. This measure is usually a self-report measure, however in this study was used to ask about perceptions of another person's attitude about therapy. Trainees were asked to fill out this questionnaire for both their mother (or maternal care-giving figure) and their father (or paternal care-giving figure). Trainees' perceptions of parental attitude were considered to come from an "internalised other" (Tomm, 1994). This "internalised other" may be experienced as, for example, critical, compassionate, supportive or hostile. These perceived views on the value of therapy, and the relationship with the "internalised other" may influence the use of personal therapy by trainees.

Childhood Trauma Questionnaire (CTQ)

The Childhood Trauma questionnaire (Bernstein and Fink, 1998) was used to find out about histories of abuse, which was deemed to be important to consider as a possible reason for the use of personal therapy. This 28-item self-report measure requires participants to respond to statements about abuse in their childhood based on a five point Likert scale. The 5 response options range from "never true" to "very often true". Increased scores demonstrate more abuse in a person's history. Five subscales were defined as emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect. A subscale on minimisation and denial was also included.

The questionnaire was validated with clinical and non-clinical groups. Internal consistency was checked with a number of groups, and a median alpha was reported for all five subscales. These ranged from $\alpha=0.92$ (sexual abuse scale) to $\alpha=0.66$ (physical neglect scale). Test-retest reliability was reported ranging from $r=0.79$ – $r=0.86$ (N=40, time scale 1.6-5.6 months). Confirmatory factor analysis showed that the five factor model was an adequate fit; all item loadings met or exceeded $\alpha = 0.5$ (Nunnally, 1978).

With a non-clinical group of women, cut scores were identified at four levels of maltreatment: none/minimal, low/moderate, moderate/severe, and severe/extreme. This was done through analysis of data and cross-checking with an in-depth trauma interview. These were found to be most sensitive with the lower severity abuse cases (sensitivity was lower then 50% in the more extreme abuse groups), but highly specific across groups.

The researchers noted that there were questions in the literature about the accuracy of memories related to trauma, specifically abuse. They argued that the

CTQ aimed to measure generic memories, which had been found to be relatively accurate. They noted that the minimisation scale would be useful in identifying people who had “forgotten” or for other reasons could not report their abuse. Three of the questions of the CTQ are concerned with minimisation or denial of abusive experiences. All statements on the CTQ are scored from 1-5; minimisation statements are then re-coded into 0 if the response is 1-4, or 1 if the response is 5.

Invalidating Childhood Experience Scale (ICES)

The ICES (Mountford, Constantine, Tomlinson and Waller, 2007) was used in order to gain an idea about difficult early relationships with parents. These early experiences were considered to have potentially had an impact on the context in which attitudes towards therapy, and issues such as self-compassion, could be understood. This 14 item questionnaire uses statements about how parents behaved towards the respondent. A five-point likert scale is used to report frequency, ranging from “never” to “all of the time”.

This questionnaire was validated with a sample of British women who experienced eating disorders ($N = 73$) and a non-clinical group of women from a university population ($N = 62$). It demonstrated good internal consistency for the clinical group ($\alpha = 0.77$ form maternal invalidation, $\alpha = 0.79$ for paternal invalidation), however more modest scores for the non-clinical group (α=.0.66 for maternal invalidation, $\alpha = 0.58$ for paternal invalidation). The ICES showed that a validating childhood environment was correlated with Distress Tolerance Scale (DTS) avoidance scores ($r = 0.37$, $p<0.01$). In the non-clinical group, maternal invalidation was associated with avoidance of affect (DTS) ($r = 0.4$, $p<0.01$).

Procedure

Recruitment of Participants

Following attainment of ethical approval, all training courses attached to the Clearing House were approached, initially by letter to the Head of Course. This outlined the purpose of the study, and asked for permission to approach trainees on the course. An email was sent following this initial contact to the Head of Course, the Course Administrator or to whichever member of the course team was allocated (for example, some of the courses' research tutor replied to the initial letter by email). This email contained a letter to trainees inviting them to participate in the study, information about the study, and a link to the online study. They were given the researcher's details, should they have wished to discuss any details of the study, and informed consent was gained at the outset of the survey. A reminder email was sent 4 months later. Copies of these letters and emails are available in Appendix B.

Collecting data

Potential participants followed a link from the invitation email to the online survey (surveymonkey.com). This website was chosen for its accessibility and ease of use. The package used (professional at $19.95 monthly) was set up for 6 months while data was being collected. Surveymonkey.com has since updated its packages; the package used in this study is closest to the current Select package. The package used in this study allowed unlimited questions, which was important in this quite detailed questionnaire, in a variety of formats. It allowed 1000 responses per month, which was considered sufficient for the 1800 potential participants. Responses were downloadable into Excel, which allowed later import into SPSS. It included a thank-you page, which served as debrief. The website at the time, could not download directly into SPSS, analyse text or data contained in the questionnaires. It was not, therefore, possible to offer to send participants their individual results via surveymonkey.

The survey began with a consent form. Participants were invited to respond to all of the questions presented via the survey. Debrief information was shown, which signposted available support and gave the researcher's details in order for them to request a copy of the study on completion. Responses were stored by the survey website for later download by the researcher into programs for analysis. The format of the survey is available in Appendix C, along with the web address.

Analysis:

Results were analysed using SPSS 18.

Standardised scales were scored as described above; using either aggregate scores, groupings by cut-off scores or mean scores. Course support for personal therapy was considered in terms having spoken about personal therapy as being useful for PPD, the provision of financial support and guidance finding a therapist. Fit between therapeutic orientations of the course and individual trainees was assessed using a likert scale.

Factual questions were answered on descriptive demographic factors and clinical status factors. Some descriptive factors were examined through multiple choice questions; age, gender, year group. Clinical status questions about previous experiences of abuse and therapy were answered through the CTQ and yes/no questions. These were explored through descriptive analysis, and differences between those who had and had not had therapy prior to training were explored to rule out the possibility of confounding. As significant differences were found, those who had used therapy prior to training were excluded from ongoing analysis.

Analysis of Aim of study:

Which factors differentiate between trainees at different stages in deciding whether to use personal therapy?

Analyses were conducted using cross-tables and Chi-square test of independence to establish whether any non-continuous demographic and/or experiential variables showed differences between groups. These were considered separately to the discriminant analysis due to statistical assumptions of the discriminant analysis, which requires continuous data.

Discriminant analysis was conducted to see which intrapersonal and interpersonal variables discriminated between groups, where the grouping criterion was the current use of personal therapy. The list of discriminators was derived from the measures described above. As this analysis rests on assumptions of normality, intra- and interpersonal variables were checked using boxplots. Missing values were replaced with the mean scores for each group, and those with more than half the relevant data missing (for example having completed only two of six relevant questionnaires) were excluded from the analysis. Variables needed to show significant differences between groups in order to proceed into analysis. This was checked using ANOVA. The discriminant analysis followed, which included the identification and labelling of discriminant functions.

Ethical Approval

The study was approved by the Psychology Ethics Committee under delegated authority from the Ethics Committee of the University of Hertfordshire on the 29th April 2010. The certificate of approval can be found in Appendix B.

Ethical approval from the University Ethics committee was deemed sufficient as this study focuses on the personal and professional development of trainee

clinical psychologists, without reference to clinical placements within the NHS. No significant concerns about ethical issues were raised. Trainees were fully informed about the purpose and aims of the study and were directed to support in the event that any of the questionnaires raised distressing issues.

Results:

Outline of Results Section:

Factual questions about the participants were answered, with reference to demographic variables and clinically relevant experiences, particularly childhood abuse and previous experience of therapy. Clinically relevant experiences were explored in some depth, in consideration of whether responses to these variables confounded the principal aim of the study. This was to consider variables that differentiated between trainees at different stages of deciding to use personal therapy during training. These variables related to demographics, experience and to specific intrapersonal and interpersonal measures. Intrapersonal measures were attitude towards therapy (including in terms of Self-sufficiency and beliefs about Personal and Professional Development - PPD), self-stigma, psychological flexibility/avoidance, self-compassion and coping (avoidant and non-avoidant). Interpersonal variables were perceived goodness of fit between course and own therapeutic orientation, social stigma, both parents attitude to seeking therapy, parental invalidation in childhood, and childhood abuse. Discriminant analyses were then conducted for salient intrapersonal and interpersonal variables, with a view to describing the most important issues in the use or non-use of personal therapy among trainees.

Some characteristics of the British trainee clinical Psychologist population:

Demographic Descriptives:

What is the age range of trainees?

As seen in Table 1, most trainees were in their late twenties and early thirties. This fits with the data generated by the Clearing House.

Table 1: Age of trainees.

	Frequency	*Percent*
21-26 years	107	25
27-32 years	274	63
33-38 years	40	9
39-44 years	10	2
45-50 years	5	1
over 50 years	1	0.2
Total	437	100

What is the gender mix of this trainee cohort?

The overwhelming majority of participating trainees were female (n=383, 88%). There were 53 male participants (12%). One participant did not answer the question.

What is the spread among year groups of this sample?

Four participants did not respond to this question. It is possible that they could not; trainees in Scotland may train over 4 or 5 years in some cases.

Table 2: Year of Training

	Frequency	*Percent*
First Year	150	34
Second Year	170	39
Third Year	113	26
Missing Response	4	1
Total	437	100

Clinically relevant experiences:

Experience of childhood trauma, such as abuse, within the trainee population has not been previously explored. It was considered that these experiences could be

important in influencing issues such as understanding relationships, self-care, and resilience.

While the study did not define the purpose of therapy as being for development or for help with problems, it is possible that trainees have had experiences that positioned them as needing help with specific issues.

Do trainees have abusive experiences in their childhood?

The CTQ (full description in Method section, p. 49) defines abuse in terms of physical, emotional and sexual abuse, and physical and emotional neglect rather than a single score for abuse. The minimum score possible is 5, indicating no abuse ever, maximum possible score is 25. The CTQ provides cut-off scores to suggest severity of abuse.

Trainee responses to questions about abuse using the cut-off scores are shown in Table 3. This showed that there were trainees who had abusive experiences in their childhood.

Table 3: Frequency and percentage of trainees meeting cut-off scores for abuse in childhood

	Physical abuse		*Emotional abuse*		*Sexual Abuse*		*Emotional Neglect*		*Physical Neglect*	
	N	%	N	%	N	%	N	%	N	%
Missing Responses	60	14	60	14	57	13	60	14	56	12
None/Minimal abuse	337	77	234	54	347	80	224	51	304	70
Low/Moderate abuse	20	5	81	18	10	2	96	22	42	10
Moderate abuse	10	2	28	6	10	2	33	8	27	6
Severe/Extreme abuse	10	2	34	8	13	3	24	5	8	2
Total	437	100	437	100	437	100	437	100	437	100

10% of trainees who responded indicated that they had experiences of multiple types of abuse. Table D1 in Appendix D demonstrates how many trainees indicated multiple types of abuse.

Descriptive statistics and distribution of responses were explored. Distribution was clearly not normal. Boxplots showing the distribution of scores on this measure are in Appendix D (Figure D5). Descriptive statistics are shown in Table 4.

Table 4: Trainee Abuse: Descriptive statistics

	N	*Mean*	*Median*	*Standard Deviation*	*Minimum score*	*Maximum score*	*Skew*
Physical Abuse	377	8.73	7	4.37	5	25	1.61
Emotional abuse	377	5.83	5	2.12	5	21	3.85
Sexual Abuse	380	5.64	5	2.72	5	25	5.00
Emotional Neglect	377	9.64	8	4.44	5	25	1.08
Physical Neglect	381	6.30	5	2.06	5	18	2.02

The relationship between subscales was then considered. Correlations (Table D2 in Appendix D) showed moderate associations between subscales. Emotional abuse and emotional neglect was the strongest correlation ($\alpha = 0.64$), and emotional neglect and physical neglect were correlated ($\alpha = 0.61$). Table 5 shows trainees experiences of emotional abuse and emotional neglect. It suggests that where there was severe emotional neglect, it was usually accompanied by moderate-severe emotional abuse.

Table 5: Emotional abuse experiences as a function of emotional neglect

	None/ Minimal Emotional Neglect	*Low/ Moderate Emotional Neglect*	*Moderate Emotional Neglect*	*Severe/ Extreme Emotional Neglect*	*Total*
None/Minimal Emotional Abuse	179 (81%)	40 (42%)	10 (31%)	0 (0%)	229
Low/Moderate Emotional Abuse	34 (16%)	32 (34%)	12 (38%)	2 (9%)	80
Moderate Emotional Abuse	4 (2%)	16 (17%)	3 (9%)	4 (17%)	27
Severe/Extreme Emotional Abuse	3 (1%)	7 (7%)	7 (22%)	17 (74%)	34
Total	220 (100%)	95 (100%)	32 (100%)	23 (100%)	370

The relationship between physical and sexual abuse with emotional abuse was considered (Tables D3 and D4 in Appendix D). This showed that where there was extreme physical abuse in childhood, there was usually also severe emotional abuse, but that this was not always true. Moderate physical abuse was usually accompanied by moderate-severe emotional abuse. There were high numbers of trainees reporting emotional abuse without physical abuse. Where there was severe sexual abuse, this was not always accompanied by emotional abuse. There were various potential reasons for this, including the perpetrator being outside the immediate family. Sexual abuse questions were worded as “someone”, whereas physical abuse questions often asked about the family.

Minimisation/Denial:

This related to measuring under-reporting of abusive experiences (see Method for full explanation of scale p. 46). The highest possible score for minimisation is 3.

Table 6 shows that there were some concerns about under reporting in this group. More than 10% of the trainees who answered questions on abuse (n=383) showed some signs of minimisation of abuse. Seven trainees demonstrated the strongest signs of minimising or denial of abuse in childhood. It was noted that none of these seven participants were in therapy in the current time.

Table 6: Trainees' minimisation of abuse

	Frequency	*Percent*
No minimization concerns	330	86
Low minimization concerns	35	9
Moderate minimization concerns	11	3
High minimization concerns	7	2
Total	383	100

How does childhood emotional abuse and emotional neglect relate to scores on intrapersonal factors in the current time?

The correlations between abuse scores and intrapersonal variables were investigated. These are shown in Table 7. For all the intrapersonal variables, mean scores of those who had suffered moderate/severe emotional abuse were compared with those who not suffered any emotional abuse. This process was repeated for those who had and had not suffered emotional neglect. Table 7 shows the variables where significant differences were found. Due to missing responses, samples sizes for the groups varied. See Tables D6 and D7, Appendix D for full details.

Those who had suffered emotional abuse or neglect had significantly higher scores for PPD (which indicates a belief that therapy is important for PPD), and scored significantly lower on measures of self-compassion and psychological flexibility. Interestingly, those who had suffered emotional abuse showed no

difference in self-kindness from those who had not been abused, and those who had been neglected showed no significant difference in self-sufficiency from those who had not been neglected. Emotional neglect seemed to have a large effect on psychological flexibility.

Table 7: Mean differences in scores on intrapersonal variables where trainees have experienced emotional abuse (n=59-62) or neglect (n=55-57), compared to where they have not experienced emotional abuse (n=218-234) or neglect (n=209-224)

		Correlation abuse-variable	*Mean difference*	*CI*	*Df*	*T*	*P*	*d*
Emotional Abuse	Attitude to therapy	0.2	-3.03	-5.22 – -0.85	284	-2.73	.007	0.40
	Self-Sufficiency	-0.13	0.26	0.08 – 0.45	294	2.79	.006	0.39
	PPD	0.3	-0.52	-0.73 – -0.32	290	-5.04	<.001	0.72
	Psychological Flexibility	-0.3	5.22	2.84 – 7.60	289	4.31	<.001	0.58
	Self-compassion	-0.21	0.26	0.07 – 0.45	275	2.7	.007	0.39
	Self-Judgement	-0.22	0.43	0.16 – 0.69	291	3.17	.002	0.46
Emotional Neglect	Attitude to therapy	0.22	-4.52	-6.68 – -2.35	273	-4.10	<.001	0.59
	PPD	0.24	-0.51	-0.72 – -0.31	277	-4.88	<.001	0.76
	Psychological Flexibility	-0.34	7.28	4.83 – 9.82	275	5.86	<.001	0.80
	Self-compassion	-0.24	0.37	0.17 – 0.57	262	3.66	<.001	0.54
	Self-kindness	-0.2	0.35	0.13 – 0.59	274	3.08	.002	0.46
	Self-judgement	-0.26	0.59	0.30 – 0.85	277	4.15	<.001	0.61

Have trainees had therapy before beginning training?

Trainees were asked if they had had psychotherapy before starting the course for any reason. Trainees were not asked if therapy had been completed or why they made the choice to use therapy.

All participants answered this question. They were grouped into those who had and had not had prior experience of therapy (PET groups = yes/no). Almost one third of trainees (n=126) had experienced therapy. This seemed like a high percentage, and so was explored further, in order to consider a possible selection bias. Given the results on abuse, whereby 115 trainees had experienced moderate/severe abuse in at least one subscale, it was considered important to explore whether there was an association between these variables.

Most trainees who had therapy before training had not had moderate/severe experience of abuse. Where trainees had experiences of moderate/severe abuse, approximately half had had therapy before training (Table D5 in Appendix D). Table 8 shows the differences in mean abuse scores between those who had therapy pre-training, and those who had not. Due to missing responses, sample sizes for the groups varied. Further details can be found with descriptive statistics in Appendix D (Table D8). Differences between mean scores were tested for significance using the Mann-Whitney U test as well as t-tests, because normality assumptions were violated.

Table 8: Differences in mean abuse scores between PET groups (yes n=105-108, no n=270-274).

	Mean difference	*CI*	*Df*	*T*	*P*	*Mann-Whitney p*	*D*
Physical Abuse	0.23	-0.25 – 0.71	375	0.93	0.35	0.067	0.11
Emotional abuse	2.13	1.08 – 3.17	164.3	4.02	<0.001	<0.001	0.48
Sexual Abuse	0.31	-0.3 – 0.92	378	1.01	0.31	0.069	0.11
Emotional Neglect	3.09	2.05 – 3.14	163.4	5.85	<0.001	<0.001	0.70
Physical Neglect	1.34	0.79 – 1.88	137.2	4.82	<0.001	<0.001	0.60

Table 8 shows that the differences in scores between PET groups were highly significant for emotional abuse, emotional neglect and physical neglect. The effect sizes were moderate to strong.

While no significant differences were shown in mean scores between physical abuse or sexual abuse, it was considered important to explore whether specific questions would show differences in therapeutic experiences pre-training. These questions were chosen for their factual outlook and good face validity.

For experience of childhood physical abuse, question 11 of the CTQ was chosen: “People in my family hit me so hard that it left me with bruises or marks”. Mann-Whitney U test showed no significant differences between the PET groups in mean scores (had therapy mean=1.17, no therapy mean=1.12, *p*=0.15). The majority of trainees who had childhood experience of being hit by someone in their family did not access therapy before training (Table D9 in Appendix D).

For sexual abuse experience, question 23 of the CTQ was chosen: “Someone tried to make me do sexual things or watch sexual things”. Mann-Whitney U tests showed no significant differences in mean scores between the PET groups

in mean scores (had therapy mean=1.38, no therapy mean=1.25, *p*=0.06). Table 9 shows the number and percentage of trainees answering this question who had used therapy pre-training and those who had not. A minority of trainees who reported more frequent abuse had therapy before training. Where this experience was rare, but happened, trainees were more likely to have had therapy. This could be understood in terms of an abusive family, where help was unavailable, compared to a single traumatic experience occurring outside of a familial context wherein help could be offered.

Table 9: Number and percentage of trainees having therapy pre-training and their experience of sexual abuse

		Someone tried to make me do or watch sexual things					
		Never	rarely true	Sometimes true	Often true	Very often true	Total
Therapy pre-training	yes	100	4	2	2	1	109
		28%	80%	40%	29%	25%	28%
	no	263	1	3	5	3	275
		73%	20%	60%	71%	75%	72%
Total		363	5	5	7	4	384
		100%	100%	100%	100%	100%	100%

This evidence suggested that, while not every trainee who had sought therapy before training was subject to severe childhood abuse, there were differences in the experiences of abuse between the PET groups. Those who had sought therapy before training had significantly higher mean scores on emotional abuse, emotional neglect and physical abuse. Exploration of specific questions suggested that where abuse was experienced, therapy was often not accessed prior to training.

It was considered how many trainees had used personal therapy where abuse was not an issue. Trainees who had reported moderate/severe abuse in any subscale were filtered out, leaving only those reporting never experiencing abuse or low/minimal abuse scores. Table 10 shows the number of trainees reporting never having experienced abuse. 75 out of the 126 (60%) trainees who reported using therapy before training had not reported any abuse in the moderate/severe categories, and reported the lowest possible scores in at least one of the subscales.

Table 10: Number and percentage of trainees using therapy with no experience of abuse

		Frequency	*Percent*
Missing subscales		17	23
All valid subscales	1 subscale	7	9
	2 subscales	21	28
	3 subscales	17	23
	4 subscales	10	13
	5 subscales	3	4
Total		75	100

There are many potential reasons for trainees having therapy before training. The literature suggests that therapy may be used for help with a problem or for personal and professional development (PPD). As trainees have to gain clinical experience before beginning a course (through being an assistant psychologist or doing other related work), they may have developed views about the purpose of therapy and how it pertains to them.

Comparisons between the PET groups: intrapersonal factors

Attitudes to therapy were explored with a view to considering differences between the PET groups. Attitude was explored through overall attitude score and through mean score on two relevant factors; self-sufficiency (the ability to solve problems without professional help) and importance for PPD. These were

current attitude scores; it cannot be said whether this was their attitude at the time of beginning therapy or whether therapy led to development of current attitude. Potential differences in other intrapersonal variables were also explored.

Table 11 shows that there were significant mean differences across all three attitude scales, with those who had used therapy pre-training scoring higher on overall attitude, and on PPD. Interestingly, those who had not had therapy pre-training reported higher mean scores for self-sufficiency (which means a lower need to be self-sufficient). Attitudes regarding therapy and PPD showed an effect size in the moderate range, which suggested that those who had therapy pre-training believed it was important for PPD and was a positive experience. Those who had not had therapy prior to training had significantly higher scores in psychological flexibility, non-avoidant coping and self-compassion, particularly self-judgement (meaning they were less judgemental towards themselves). Perhaps this suggests that those who did not have therapy prior to training felt more confident in their abilities to manage life's difficulties. A full Table of means, sample sizes and descriptive data is in Appendix D (Table D10). Sample sizes varied due to missing data.

Table 11: Mean differences between PET groups (yes n=106-120, no n=272-296).

	Mean difference	*CI*	*Df*	*T*	*P*	*d*
Overall attitude	2.2	0.47 – 3.93	387	2.495	0.01	0.28
Self-sufficiency mean	-0.20	-0.35 - -0.06	397	-2.78	0.006	0.31
PPD mean	0.39	0.23 – 0.56	394	4.92	<0.001	0.56
Psychological Flexibility	-5.30	-7.15 – -3.44	404	5.62	<0.001	0.60
Self-Compassion	-0.26	-0.41 – -0.11	376	-3.38	0.001	0.38
Self-judgement	-0.26	-0.47 – -0.06	399	-2.51	0.013	0.27
Avoidant coping	0.13	0.01 – 0.25	408	-2.06	0.04	0.23
Non-avoidant coping	-0.24	-0.46 – -0.02	414	-.2.21	0.028	0.24

What is trainee current use of personal therapy (PT)?

Trainees responded to four options, which represented stages of decision making. These led to the grouping of participants into four PT groups. All participants responded to this question. Table 12 shows the number of trainees in each PT group. If those in therapy and those recently ended are grouped together, it can be seen that approximately one third of trainees have had some experience of personal therapy during training.

Table 12: Trainees' current use of personal therapy

	Frequency	*Percent*
not considering it (group 1)	138	31
Actively considering it (group 2)	144	33
In therapy (group 3)	104	24
recently ended (group 4)	51	12
Total	437	100

It was important to determine whether previous use of therapy impacted on trainees' current use of personal therapy, particularly as there were differences on various measures between the PET groups. Table 13 shows percentages of current therapy usage by those with and without previous experience of therapy. Those without previous experience were more likely to be in group 1 or 2. More than 50% of those who have had experience of therapy previously to the course were currently in therapy or have recently ended therapy.

The percentages of personal therapy usage differed significantly between PET groups, Chi-square (3) = 34.52, $p<0.001$. This was a small-medium effect size, Cramer's V=0.28, $p<0.001$.

Table 13: Current use of personal therapy and previous therapy experience.

	Previous experience	*No previous experience*	*Total*
1. Not Considering therapy	27 (21%)	111 (36%)	138
2. Actively considering therapy	28 (22%)	116 (37%)	144
3. In therapy	50 (40%)	54 (17%)	104
4. Recently ended therapy	21 (14%)	30 (10%)	51
Total	126 (100%)	311 (100%)	437

Due to concerns about selection bias, it was decided that those who had used therapy previously to beginning training (n=126) should be excluded from further analysis. It was decided that PT groups 3 and 4 would be combined in order to manage differences with sample size between groups, and because analysis demonstrated no significant differences between these groups on any variables. The revised PT groups were thus:

- Group 1: Not considering personal therapy (n=111)
- Group 2: Actively considering personal therapy (n=116)
- Group 3: Used/using personal therapy (n=84)

Experiences of abuse and current use of personal therapy

Experience of abuse is differentially spread across the three PT groups; 11% of group 1 had experience of moderate/severe abuse in at least one subscale, 20% of those in group 2 met this criteria, and 35% of those in group 3 have experienced moderate/severe abuse. Table 14 shows that as the number of subscales within which moderate-severe abuse was reported increased, so did the percentage of trainees considering, or using therapy. Where trainees reported never having experienced abuse (n=247), there was a spread across therapy groups, although trainees were least likely to be using therapy.

Table 14: Trainees' use of therapy considering moderate/severe childhood abuse

Moderate/severe Abuse	*Not Considering therapy*	*Actively considering therapy*	*Used/Using therapy*	*Total trainees reporting moderate/severe abuse*
0 scales	99 (40%)	93 (38%)	55 (22%)	247 (100%)
1 scale	11 (26%)	15 (36%)	16 (38%)	42 (100%)
2 scales	1 (10%)	2 (20%)	7 (70%)	10 (100%)
3 scales	0 (0%)	4 (50%)	4 (50%)	8 (100%)
4 scales	0 (0%)	2 (100%)	0 (0%)	2 (100%)
5 scales	0 (0%)	0 (0%)	2 (100%)	2 (100%)
Total	111	116	84	311

T-tests were conducted within each PT group to look for differences in mean scores between those who had and had not experienced moderate/severe abuse. No significant differences in mean attitude towards therapy (p=0.42), psychological flexibility (p=0.72), self-compassion (p=0.71), or self-stigma (p=0.46) were found in any of the current therapy groups based on experience of

abuse. This seemed to rule out significant within group differences based on experience of abuse.

Exploring Intrapersonal and Interpersonal variables:

This section will consider how variables were distributed within and between the three PT groups and will also aim to consider how they may relate to each other.

One-way ANOVAs were conducted to explore the means of the three PT groups on six intrapersonal variables. Pairwise mean comparisons with Bonferroni correction were used as follow up procedure, in case of significant rejection of the null hypothesis. These results are shown in Tables 15 and 16. Full descriptive statistics are in Appendix D (Table D11).

Significant results for the ANOVA were obtained for all variables except self-sufficiency and avoidant coping. Table 16 suggests that the differences were most robust for PPD. Psychological flexibility showed differences between three groups. Attitude to therapy also showed differences between two of the three groups; attitude to therapy means suggested that those considering therapy may be closer to the opinion of group 3 than group 1. This could be understood in terms of moving through stages of change.

Table 15: Results from ANOVA calculations on Intrapersonal variables

Intrapersonal variable	*F*	*Df*	*P*	*Eta-squared*
PPD	64.21	2, 279	<0.001	0.315
Attitude to therapy	22.00	2, 274	<0.001	0.138
Psychological Flexibility	21.95	2, 291	<0.001	0.131
Self-compassion	6.73	2, 269	0.001	0.048
Self-stigma	5.37	2, 274	0.005	0.038
Avoidant coping	3.35	2, 291	0.04	0.022
Self-sufficiency	2.40	2, 282	0.09	0.017
Non-avoidant coping	1.72	2, 293	0.18	0.012

Table 16: Differences between therapy groups with Bonferroni adjusted p-values.

Variable	*Groups compared*		*Mean difference*	*P*
PPD	Group 1	Group 2	-0.60	<0.001
	Group 1	Group 3	-1.01	<0.001
	Group 2	Group 3	-0.41	<0.001
Attitude to therapy	Group 1	Group 2	-4.72	<0.001
	Group 1	Group 3	-7.01	<0.001
	Group 2	Group 3	-2.30	0.11
Psychological flexibility	Group 1	Group 2	2.74	0.026
	Group 1	Group 3	7.32	<0.001
	Group 2	Group 3	4.58	<0.001
Self-Compassion	Group 1	Group 2	0.21	0.056
	Group 1	Group 3	0.35	0.001
	Group 2	Group 3	0.14	0.483
Self-Stigma	Group 1	Group 2	1.16	0.052
	Group 1	Group 3	1.63	0.006
	Group 2	Group 3	0.47	1.00
Avoidant coping	Group 1	Group 2	-0.18	0.061
	Group 1	Group 3	-0.18	0.111
	Group 2	Group 3	0.01	1.00

One-way ANOVAs also revealed significant differences between the groups on six intrapersonal variables. Bonferroni tests showed that there were significant between group differences. These results are shown in Tables 17 and 18. Full descriptive statistics are in Appendix D (Table D13). It is noted that maternal attitude and invalidation show significant differences between the groups, whereas paternal factors do not.

The largest differences exist between group 1 and 3 (Table 18). The groups show the most robust differences in scores on emotional and physical neglect, with those in the therapy group scoring higher.

Table 17: Results from ANOVA calculations on Interpersonal variables

Intrapersonal variable	*F*	*Df*	*P*	*Eta-squared*
Emotional Neglect	11.13	2, 267	<0.001	0.077
Physical Neglect	9.73	2, 271	<0.001	0.067
Emotional Abuse	7.23	2, 267	0.001	0.051
Physical Abuse	5.02	2, 269	0.007	0.036
Maternal attitude to therapy	4.41	2, 263	0.01	0.032
Maternal Invalidation	4.20	2, 263	0.02	0.031
Paternal attitude to therapy	2.17	2, 258	0.12	0.017
Paternal Invalidation	2.07	2, 250	0.13	0.016
Fit between Therapeutic orientations	1.88	2, 308	0.15	0.012
Sexual Abuse	0.67	2, 269	0.51	0.005
Social stigma	0.19	2, 276	0.83	0.001

Table 18: Differences between groups using Bonferroni adjusted p-values.

Variable	*Groups compared*		*Mean difference*	*P*
Emotional Neglect	Group 1	Group 2	-1.06	0.158
	Group 1	Group 3	-2.74	<0.001
	Group 2	Group 3	-1.68	0.012
Physical Neglect	Group 1	Group 2	-0.38	0.272
	Group 1	Group 3	-1.05	<0.001
	Group 2	Group 3	-0.67	0.015
Emotional Abuse	Group 1	Group 2	1.27	0.07
	Group 1	Group 3	-2.24	0.001
	Group 2	Group 3	-0.97	0.304
Physical Abuse	Group 1	Group 2	-0.52	0.271
	Group 1	Group 3	-1.03	0.005
	Group 2	Group 3	-0.51	0.337
Maternal attitude to therapy	Group 1	Group 2	-0.25	1.00
	Group 1	Group 3	2.66	0.043
	Group 2	Group 3	2.91	0.019
Maternal Invalidation	Group 1	Group 2	-0.09	0.110
	Group 1	Group 3	-0.12	0.019
	Group 2	Group 3	-0.04	1.00

The relationship between some of these significant variables was considered using correlational analysis (Table 19). Sample size varied due to missing

responses. This suggested that increased abuse and neglect scores were related to lower psychological flexibility scores, though the correlation was modest.

Table 19: Correlations between important variables (n=261-277)

	Psychological Flexibility	*Attitude to therapy*	*PPD*	*Emotional Abuse*
Attitude to therapy	-.38			
PPD	-.29	.71		
Emotional abuse	-.24	.18	.29	
Emotional neglect	-.19	.16	.17	.69

Correlations significant at p=0.01.

Which factors differentiate between trainees at different stages in deciding whether to use personal therapy?

Demographics and Orientation.

This section will consider the impact of non-continuous variables in differentiating between PT groups (n=311). Chi-square tests of independence were used to consider whether variables differed between the therapy groups.

Age of Trainees:

Assumptions of the Chi-square were violated because of the uneven spread of participants across the groups; there were very small numbers of trainees in the older age groups. This meant that the test could not reliably be used to consider whether ages of trainees differed between the therapy groups. While age was recorded categorically, the categories ran continuously. Mean age group for each therapy group was calculated as 21-26 years.

Gender

Gender did not reliably distinguish between groups. While more female trainees participated in the study, the spread among the groups was similar.

Year of training

There were differences in the use of personal therapy between the year groups. Table 20 shows that trainees who were using or have used therapy were second years more frequently than first or third years (46%). Group 1 (not considering therapy) has a slightly higher proportion of first years (44%) than second years, as does Group 2 (actively considering therapy - 41%). While second and third years seem to be spread among all three groups, 85% of first years were in the groups 1 or 2. Second and third years were most often in group 3.

Chi-square test assumptions were not violated. The differences between the groups were significant, Chi-square (4) = 22.14, $p<0.001$. This was a small effect, Cramer's V = 0.19, $p<0.001$.

Table 20: Year of training and use of personal therapy

	First Year	*Second Year*	*Third Year*	*Totals*
1. Not Considering therapy	49 (44%)	45 (41%)	17 (15%)	111 (100%)
2. Actively considering therapy	47 (41%)	42 (37%)	26 (23%)	115 (100%)
3. Used/using therapy	14 (17%)	48 (46%)	31 (37%)	83 (100%)
Totals	110	125	74	309

Therapeutic orientation of self

Therapeutic orientation was measured using a multiple choice question, in which trainees could tick several boxes. As the literature suggests that CBT and Psychodynamic models have the clearest views on the need for personal therapy in training, the analysis focussed on the inclusion of these models in the choices.

Table 21 shows how the responses were distributed among the groups. Distribution is somewhat influenced by the dominance of CBT orientation. Trainees who were psychodynamically orientated (as opposed to CBT) were in the minority. 20 had been excluded because they had previous experience of therapy (almost half of original sample in this group).

Chi-square test assumptions were not violated. It can be seen that there were significant differences in therapeutic orientation between the personal therapy groups, Chi-square (6) = 18.16, $p=0.006$. This amounted to a small effect size, Cramer's V=0.17, $p=0.006$.

Within orientation however, trainees appear to conform to model position; CBT-orientated trainees usually were not considering therapy (42%), whereas

psychodynamically-orientated trainees were slightly more likely to be in group 3 (39%). Within therapy groups, orientation shows an effect. CBT does not advocate personal therapy, and the highest percentage of trainees who were not considering personal therapy were CBT orientated.

T-tests were conducted to consider whether there were significant differences between those whose orientation included CBT and those whose orientation included psychodynamic models in their attitude to therapy. While there was no significant difference in overall attitude scores, or other intrapersonal variables, there were significant differences in mean PPD score (CBT mean = 5.56; psychodynamic mean = 6.08), $t(78.81) = -4.13$, $p<0.001$. This is a moderate-large effect, Cohen's d=0.79.

Table 21: Therapeutic orientation of trainee and use of Personal Therapy.

	Therapeutic orientation does not include CBT or Psychodynamic models	*Therapeutic orientation includes CBT but not Psychodynamic models*	*Therapeutic orientation include Psychodynamic models but not CBT*	*Therapeutic orientation includes CBT and Psychodynamic models*	*Totals*
1. Not considering therapy	31 (28%)	58 (52%)	6 (5%)	16 (15%)	111 (100%)
2. Actively considering therapy	20 (17%)	50 (43%)	8 (7%)	38 (33%)	116 (100%)
3. Used/using therapy	27 (32%)	30 (36%)	9 (11%)	18 (21%)	84 (100%)
Totals	78	138	23	72	311

Therapeutic orientation of course

Therapeutic orientation of the course was measured using the same method as therapeutic orientation of self.

Only 7 participants rated the course on which they trained as having a psychodynamic but not CBT orientation, while 150 said their course was CBT-orientated but not psychodynamic. This meant that assumptions of the Chi-square test were violated, and could not be reliably used to consider whether course therapeutic orientation differentiated between groups.

Perceived attitude of Course to therapy

1. Has the course spoken about personal therapy as a means of personal and professional development?

Those not considering therapy were most likely to not know how their course positions itself on this issue (14% of participants in group 1 did not answer the question, compared to 6% in group 2 and 4% in group 3).

Table 22 shows that most trainees remember courses talking about personal therapy as a means of PPD. Where this was not spoken about, 51% of participants were not considering therapy. It can be seen that where courses talk about personal therapy for PPD, a higher percentage use therapy (group 3) while fewer were in therapy if the course has not spoken about this issue. It also seems that more trainees consider therapy when courses were perceived as having spoken about it.

Assumptions for Chi-square test were not violated. A significant difference was observed between the groups in whether the course had spoken about therapy with regards to PPD, Chi-square (2) = 11.75, p=0.003. The effect size was small, Cramer's V=0.2, p=0.003.

Table 22: Use of personal therapy by trainees considering course attitude.

	Course did not speak about therapy	*Course did speak about therapy*	*Total (group N)*
1. Not Considering therapy	34 (51%)	62 (28%)	96 (111)
2. Actively considering therapy	19 (28%)	91 (41%)	110 (116)
3. Used/using therapy	41 (21%)	67 (31%)	81 (84)
Total	67 (100%)	220 (100%)	287

2. Does the course provide financial support for personal therapy?

Most trainees report that there is no financial support for personal therapy from the course on which they train. It is again notable that trainees in group 1 were more likely to be less aware of the possibilities for support around personal therapy (17% of possible responses missing; compared to 6% for group 2, and 4% for group 3).

Table 23 shows that there were biggest differences associated with financial support in groups 1 and 3. Where financial support is available, trainees were more likely to have used therapy (group 3). The lack of financial support does not deter a proportion of trainees from entering therapy.

Chi-squared assumptions were not violated. A significant difference in between the groups was shown, Chi-square (2) = 17.45, p <0.001. The effect size was small, Cramer's V=0.25, p<0.001.

Table 23: Use of personal therapy and financial support from the course.

	Financial support not available	*Financial support available*	*Total (group N)*
1. Not Considering therapy	79 (38%)	13 (18%)	92 (111)
2. Actively considering therapy	82 (39%)	27 (37%)	109 (116)
3. Used/using therapy	47 (23%)	34 (46%)	81 (84)
Total	208 (100%)	74 (100%)	282

3. *Is there someone on your course who can give you guidance on finding a therapist?*

232 (75%) trainees answered this question. Failure to answer this question was spread quite evenly across the groups. Chi-square test showed no significant differences between the groups in terms of whether there was someone on the course to give guidance on finding a therapist.

Discriminant analysis:

Discriminant analysis aims to predict group membership from a set of predictors. The grouping variable in this study is PT group. These will be referred to as:

- Group 1 (not considering it)
- Group 2 (actively considering it)
- Group 3 (used/using therapy)

Separate discriminant analyses were conducted for intrapersonal and interpersonal factors. Missing data was accounted for in both cases (see Method, p 55). Discriminant analysis rests on the assumption of normality in distribution of continuous variables. This assumption was checked using boxplots (Figures D1-D5 Appendix D) and through examination of descriptive statistics. Between group ANOVA showed that variables were different between the groups (p. 75-77). Discriminant functions were thereafter identified and discussed.

Intrapersonal Factors

The intrapersonal factors being investigated were:

- Attitude towards therapy
    - Self-sufficiency
    - PPD
- Self-stigma
- Psychological Flexibility/avoidance
- Self-compassion
- Avoidant coping
- Non-avoidant coping

Dealing with Incomplete Data sets:

Almost 80% of participants answered all questions for the salient intrapersonal variables. Participants who failed to complete at least half of the questionnaires on salient discriminators were excluded from the sample (n=21), leaving a total sample of 290.

Exploration of the data:

The boxplots (Figure D1 and D2, Appendix D) showed fairly normal distribution of these variables. While there were some outliers, there were no extreme cases or obvious skew. The Coping, Self-sufficiency, PPD and Self-Compassion scales use mean scores from the scales, while the remaining scales use aggregate scores.

ANOVA was used to determine whether there were significant differences between the groups. This was important in determining whether variables should be included in the discriminant analysis (see Table 15 p. 77). Six variables showed significant differences between the groups. These were Attitude to therapy, PPD, and Self-stigma, Psychological Flexibility, Self-compassion, and Avoidant coping. These variables proceeded into the discriminant analysis; they showed differences between the groups and each variable accounted for more than 2% of the explained variance in scores.

Descriptive statistics are shown for these variables across the therapy groups in Table 24. Figure 4 shows the profile of mean scores for the three PT groups. Group 2 is noted as remaining near the mean for all variables. Large differences in scores can be observed between group 1 and 3 in PPD, psychological flexibility and attitude to therapy.

Table 24: Intrapersonal Factors: descriptive statistics across PT groups

Intrapersonal variable	*Group N*	*Group mean scores*	*Median*	*Std Deviations*	*Minimum score*	*Maximum score*	*Skewness*
Attitude to therapy	Group 1 = 105	73.62	74	7.77	54	91	-0.23
	Group 2 = 104	78.03	78.5	7.38	60	101	0.04
	Group 3 = 81	80.27	80	5.66	66	94	0.29
PPD	Group 1 = 105	5.15	5.13	0.65	3.63	6.75	-0.04
	Group 2 = 104	5.73	5.75	0.60	3.63	7.00	-0.35
	Group 3 = 81	6.13	6.13	0.53	4.63	7.00	-0.30
Self-stigma	Group 1 = 105	26.98	26.16	3.56	20	35	0.53
	Group 2 = 104	25.88	26.0	3.29	19	34	0.16
	Group 3 = 81	25.46	25.0	3.18	21	35	0.66
Psychological Flexibility	Group 1 = 105	56.49	56.0	6.98	42	70	0.17
	Group 2 = 104	54.01	55.0	6.97	38	70	-0.29
	Group 3 = 81	49.21	49.0	8.62	20	67	-0.44
Self-compassion	Group 1 = 105	3.42	3.35	0.68	1.85	5.00	0.07
	Group 2 = 104	3.22	3.25	0.61	1.92	4.65	0.07
	Group 3 = 81	3.09	3.11	0.53	1.85	4.19	0.15
Avoidant coping	Group 1 = 105	4.36	4.48	0.58	2.83	5.67	-0.13
	Group 2 = 104	4.54	4.50	0.52	3.33	5.83	0.14
	Group 3 = 81	4.55	4.50	0.53	2.83	5.67	-0.72

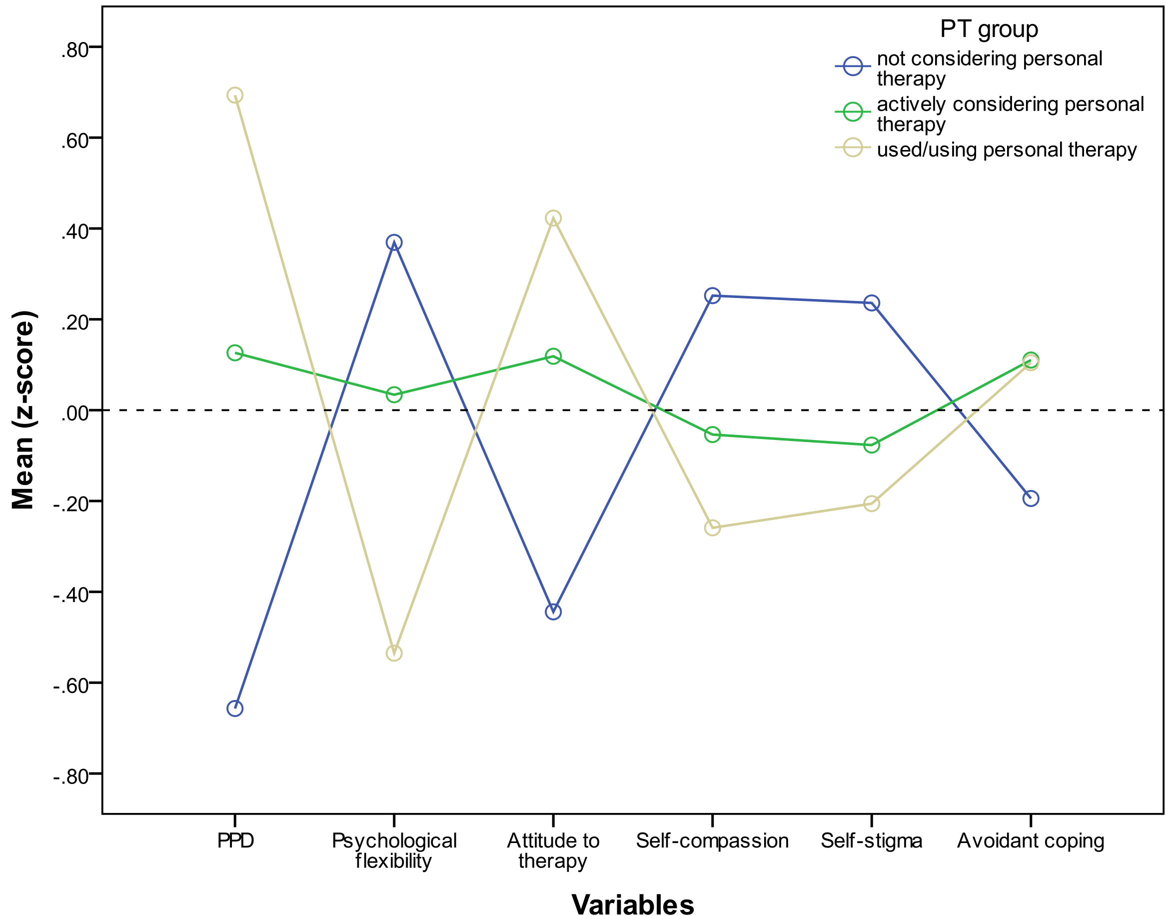

Figure 4: profile of means of PT groups across intrapersonal variables (z-scores).

Correlations between these factors were explored (Appendix D Table D12). The highest correlations found were between Attitude to therapy and PPD (α=0.71) and between Psychological Flexibility and Self-Compassion (α = 0.60). These were not considered to be high enough to invalidate the analysis.

Discriminant analysis: Intrapersonal variables.

A step-wise discriminant analysis was conducted so that only robust discriminators were used. Three predictors made significant contribution to

predicting the use of personal therapy by trainees. These were PPD, psychological flexibility and self-stigma. Preliminary statistics for the discriminant analysis indicated significant differences in means on predictors between the therapy groups. There were no significant differences in the covariance matrices among the three groups (p=0.234 for the Box's M test).

The overall Wilks' lambda was significant, lambda = 0.62, Chi-square (6, N = 290) = 136.78, p<0.001, indicating that overall the predictors differentiated among the three PT groups. The eigenvalues (0.60) suggest that this function accounts for 37% of the variance in scores. The residual Wilks' lambda was not significant (p=0.20) and therefore no further discriminant function will be interpreted.

Table 25 shows the correlations between the predictors and discriminant function, and the standardised weights. The function is characterised by a strong negative relationship with PPD and a strong positive relationship with psychological flexibility. This suggests that the discriminant function is strongly correlated with views about the necessity of therapy for development, and a person's psychological flexibility (or minimal levels of experiential avoidance). At one end of the function, is the belief that therapy is necessary for PPD, and at the other end is high psychological flexibility (and low experiential avoidance). This function was therefore labeled "development and connectedness", to recognize that those with high PPD scores tended to have low connectedness (psychological flexibility) scores, and vice versa.

Table 25: Standardised correlations and weights of intrapersonal predictor variables and discriminant function

	Correlation coefficients with discriminant function	*Standardised weights for discriminant functions*
PPD	-.858	-.787
Self-stigma	.243	.343
Psychological Flexibility	.493	.491

The means on the discriminant function were consistent with this interpretation. Those not considering therapy had the highest mean scores on this function (M = 0.906). Those in the used/using therapy group had the lowest mean scores (M = -1.011). Those actively considering therapy had scores in between these points (M = -0.128). This suggests that those using therapy believe that therapy is necessary for their development; this may include development in psychological flexibility. Those not considering therapy have high psychological flexibility scores and do not consider that therapy is necessary for development.

Interpersonal Factors:

The interpersonal factors being investigated were:

- Perceived goodness of fit between course and own therapeutic orientation
- Social stigma
- Parental attitude to seeking therapy
    - Maternal attitude
    - Paternal attitude
- Parental invalidation in childhood
    - Maternal invalidation
    - Paternal invalidation
- Childhood Abuse
    - Emotional abuse
    - Physical abuse
    - Sexual abuse
    - Emotional neglect
    - Physical neglect

Managing incomplete data sets

80% of participants answered all the questions for the interpersonal variables. This left a total sample of 274.

Exploration of the Data:

Examination of the boxplots (Figure D3-D5, Appendix D) show that distribution of these variables was not normal. Parental attitude scores were the exception to this pattern; while there were outliers, there were no extreme cases or obvious skew. Scores on perceived fit between the course therapeutic orientation and the trainees' and on social stigma suggested a positive skew. Abuse scores showed strong positive skews and completely abnormal distribution. The previous section of the Results chapter explores the issue of abuse among trainees in more detail (p. 61). Invalidation in childhood by maternal figures also showed positive skews, with outlying and extreme cases, while invalidation by paternal figures showed a somewhat more normal distribution.

ANOVA was used to determine whether there were significant differences between the groups. Results of these calculations are shown in Table 17 (p. 77). Six variables showed significant differences between the groups. These were Maternal attitude to therapy, Maternal invalidation, Emotional abuse, Physical abuse, Physical neglect and Emotional neglect.

While all abuse scores showed some positive skew, the skew for physical abuse and physical neglect (both show a skew of more than 2 across groups – see Appendix D) meant that it was not possible to include these variables in the discriminant analysis. The remaining four variables were taken forward to be included in the analysis. Significant differences were found between the PT groups and each variable accounted for more than 2% of the variance.

Descriptive statistics for these four variables are shown in Table 26. Figure 5 shows the profile of mean scores for the three PT groups. The largest differences were observed between PT groups on emotional neglect.

Table 26: Significant Interpersonal Factors descriptive statistics.

Interpersonal variable	*Group N*	*Group mean scores*	*Median*	*Std Deviations*	*Minimum score*	*Maximum score*	*Skewness*
Maternal Attitude to therapy	Group 1 = 96	15.31	15	6.06	1	27	-0.23
	Group 2 = 100	15.58	16	7.09	0	30	-0.18
	Group 3 = 78	12.72	12	7.31	0	30	0.33
Maternal Invalidation in Childhood	Group 1 = 96	2.25	2.21	0.20	1.79	3.14	1.58
	Group 2 = 100	2.35	2.29	0.29	1.64	3.71	1.48
	Group 3 = 78	2.37	2.32	0.34	1.71	3.64	1.59
Emotional Abuse	Group 1 = 96	7.04	6.0	2.42	5	16	1.79
	Group 2 = 100	8.29	7.0	4.20	5	24	1.80
	Group 3 = 78	9.18	8.0	4.68	5	25	1.77
Emotional Neglect	Group 1 = 96	7.6	7.0	2.63	5	17	1.19
	Group 2 = 100	8.67	7.0	4.14	5	24	1.68
	Group 3 = 78	10.3	10.0	4.39	5	23	0.69

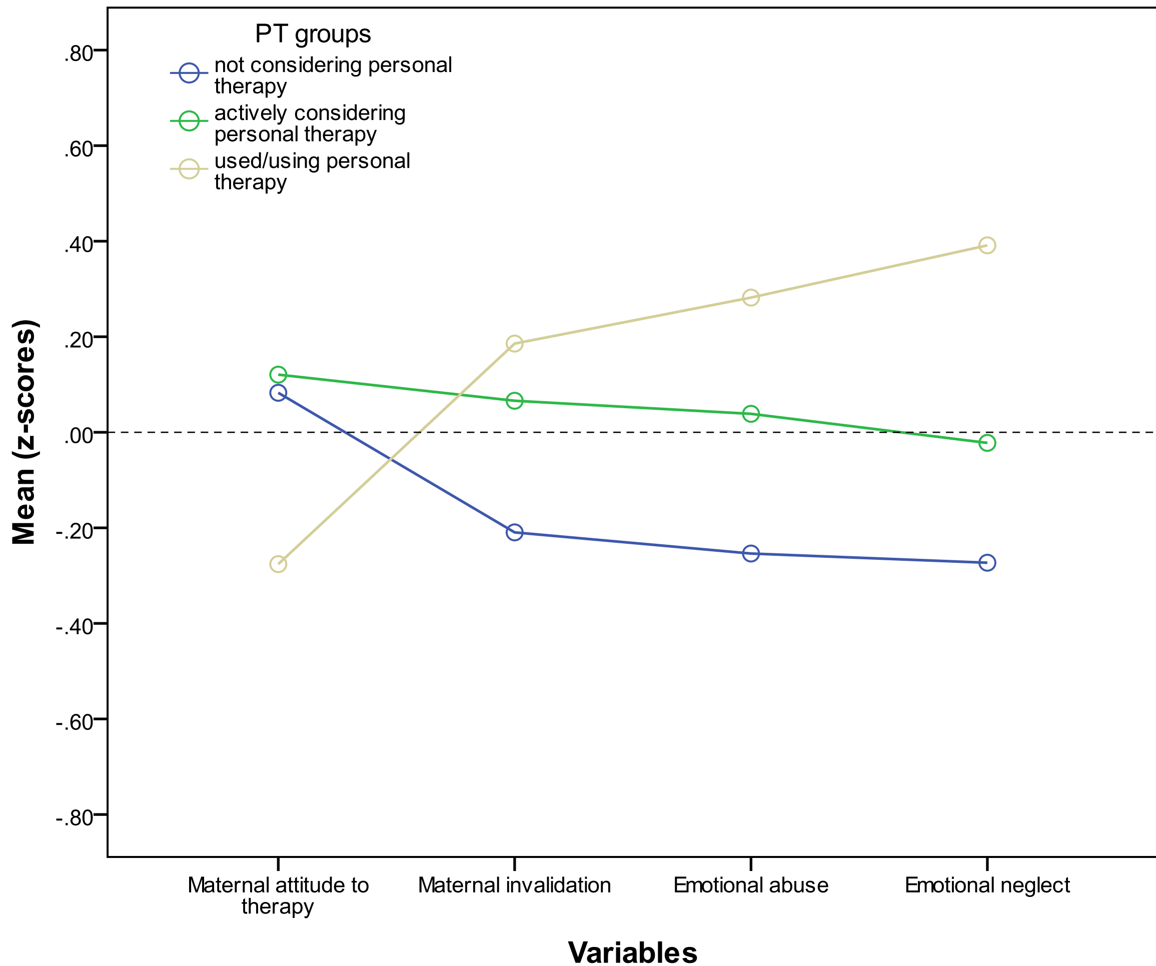

Figure 5: profile of means of PT groups across interpersonal variables (z-scores).

Correlations between these factors were explored (Appendix D Table D15). The highest correlation found was between Emotional abuse and Emotional neglect (α = 0.68). This was not considered to be high enough to invalidate the analysis.

Discriminant analysis: Interpersonal variables.

A Discriminant analysis was conducted to determine whether four predictors – Maternal attitude to therapy, maternal invalidation, emotional abuse, and emotional neglect – could predict use of personal therapy by trainees. Preliminary statistics for the discriminant analysis indicated significant differences in means on predictors between the therapy groups. There were also, however, significant differences in the covariance matrices among the three groups ($p<0.001$). This could have been due to unequal sample sizes, and different scaling methods in questionnaires.

The overall Wilks' lambda was significant, lambda = 0.90, Chi-square (8, N = 274) = 28.43, *p*<0.001, indicating that overall the predictors differentiated among the three groups. The eigenvalues suggest that this function accounts for 8% of the variance in scores. Residual Wilks' lambdas were not significant.

Table 27 shows the correlations between the predictors and discriminant function, and the standardised weights. It can be seen that emotional neglect has the strongest relationship with the discriminant function at one end of the function, with maternal attitude to therapy at the other end of the function. This suggests that this function is characterised by high scores of emotional neglect. This function is therefore labeled "neglected".

Table 27: Standardised correlations and weights of intrapersonal predictor variables and discriminant function

	Correlation coefficients with discriminant function	*Standardised weights for discriminant functions*
Maternal attitude to therapy	-.531	-.211
Maternal invalidation	.539	.204
Emotional abuse	.727	.019
Emotional neglect	.952	.802

The means on the first discriminant function show that those in the used/using therapy group had the highest mean scores for the "neglected" dimension, (group 3 mean = 0.43). Those not considering therapy had the lowest mean (group 1 mean = -0.32), and those actively considering therapy had a neutral mean (group 2 mean = -0.03).

Intrapersonal and Interpersonal Variables:

Correlations show that the four important variables identified by the discriminant analysis were correlated. Table 28 shows that these correlations were modest. Maternal attitude is positively correlated with psychological flexibility, but negatively correlated to PPD. This may be because the parental attitude scale focussed on help-seeking.

Table 28: Correlations between discriminating variables.

	Psychological flexibility	*Maternal attitude to therapy*	*PPD*
Emotional Neglect	-0.19**	-0.36**	0.17**
Psychological flexibility		0.18**	-0.29**
Maternal attitude to therapy			-0.15*

** significant at p=0.01, * significant at p=0.05

The two discriminant functions found suggest that group 1 is characterised by less experience of emotional neglect, high psychological flexibility, and low belief that therapy is important for PPD. Group 3, who were in therapy, have more experience of emotional neglect, low psychological flexibility scores and more belief that therapy is important for PPD.

Discussion

Outline of Discussion

This chapter will discuss the initial aims of the study first, despite their secondary importance. This is because findings about the trainee population, particularly regarding clinically relevant experiences, were important in considering how to understand which variables were important in differentiating between current therapy use groups. Discussion of the factors which differentiate between stages of current therapy use among trainees will follow, with reference to findings from discriminant analyses of intrapersonal and interpersonal factors, and other demographic factors. The findings will be considered in relation to relevant literature.

This study raises a number of issues, and answers some questions about trainees. It was limited by methodological and other issues; the impact of these on the study and it's findings will be discussed. This study has offered an insight into some aspects of the use of personal therapy among trainees, for example, prevalence of use and factors that differentiate between those who do and do not use therapy. There are number of further questions that cannot be answered by this study, but that may be interesting avenues for future research; these will be discussed.

Trainee Characteristics

Demographics:

Most trainees participating in the study were in their late twenties to early thirties. A very high proportion of the participants were women. There was a fairly even spread across the three year groups. This suggests that the participants are reasonably representative of the trainee population. The Clearing House website suggests that most trainees are female, in their late twenties. It is a useful feature of this sample that there is a spread across year groups, as this means that all stages in training and thus different developmental stages are represented.

Clinically relevant Experience:

Experience of Abuse

Questions on abuse were answered by approximately 88% of the sample. Responses suggest that, while most trainees do not have abusive experiences in their background, between 5-15% of trainees reported experiences of abuse that fit into moderate or more severe groupings. Experience of childhood abuse is widely considered to be traumatic and long-lasting in its impact on relationships (Briere, 1992). This study showed that increased abuse scores were linked with lower psychological flexibility and self-compassion. This was particularly true of those who had experienced emotional neglect. This fits with ideas that we learn how to understand and manage our emotions through relationships in childhood (Fonagy, Gyorgy and Jurist, 2004); where this relationship is not nurturing it is less likely that these skills will develop.

This is likely to be an important consideration for those in the helping professions, where providing a containing and nurturing space is likely to be fundamental. It was noted that trainees with childhood experiences of moderate-severe abuse often had not had therapy before beginning training, however as severity of abuse in childhood increased, so did the number of trainees considering or using therapy in the current time. Trainees with these experiences thought that therapy was very important for their personal and professional development. Perhaps therapy is viewed as an opportunity for learning skills that were not learned from relationships with parents in childhood. Trainees may consider that through therapy they could experience a different relationship that could then be replicated personally and professionally. This fits with ideas about therapy as reparative for early attachment difficulties (Winnicott, 1965) and as a socialisation experience (Norcross, 2005). This could be considered in terms of help-seeking, and also in terms of development; sometimes a difficulty needs to be addressed, perhaps with help, before a person can move forwards.

Some trainees were noted as having high scores on the minimisation scale. While there are acknowledged difficulties with scales of this type, it is noted that none of those who scored most highly on this scale were in the using/used therapy group in the current time. A lack of connection to painful experiences may have implications for clinical and reflective practice. Thomas (2004) suggested that being disconnected from one's own struggles leads to emotional

distance between the therapist and the client. Early relationships may set a template for relationships (Levitt, 1991); difficulties with intimacy in relationships may co-exist with difficulty with intimacy in the therapeutic relationship. This may have implications for therapeutic alliance.

Previous therapy

Nearly a third of trainees had experienced therapy prior to beginning training. There are no prevalence studies with trainees thus far; however this seemed a large proportion when considering therapy use by the general public. da Silva and Blay (2010) found in their review that most studies showed a prevalence rate of 1-2% in the general population.

There were higher scores for emotional abuse, emotional neglect and physical neglect among those who had used therapy pre-training. This may suggest that some trainees may have used therapy to gain help with addressing these issues. Many who had experienced abuse had not had therapy prior to the course, although trainees experiencing more severe abuse did go on to consider therapy or have therapy during training. Perhaps at this point a need to address particular issues became more apparent. Training may be a time when family stories (Dallos, 1997) about what happened may be questioned more robustly through theoretical or clinical learning. It may become increasingly difficult to disconnect from one's own experiences, when faced with similar experiences in others.

It may not have felt possible or desirable to connect with painful issues earlier in life. The imperative of being able to build a good therapeutic alliance may mean, however, that trainees felt they had to go into therapy to address difficulties. Norcross' (2005) review stated the value of personal therapy in increasing awareness of personal dynamics and thus managing the therapeutic alliance. Ackerman and Hilsenroth (2003) found, in their review, that therapist characteristics and skills both impacted on alliance. Qualities included warmth, confidence, interest and honesty. Skills included reflective listening, facilitating the expression of affect and attending to the patient's experience. These skills may not be naturally occurring if they have not been learned through early relationships (Fonagy et al, 2004). Early experiences, or responses to these, may be blind spots (leading to counter-transference), which can prevent a

therapist engaging with or understanding the client, or may be spoiling of the therapist's attitude toward the client (Sandler, Holder and Dare, 1970). Counter-transference may limit the therapist's ability to understand the client's experience, but also be less accessible to the therapist. Counter-transference may lead to negative feelings toward the client, which Ackerman and Hilsenroth (2003) note as disruptive to therapeutic alliance. Sandler et al (1970) and Norcross (2005) noted the value of therapy in unpicking these issues; trainees in this study who had experienced abuse also seemed to see therapy as a way forward.

Previous therapy and attitudes regarding PPD

The majority of trainees who used therapy prior to training had not experienced abuse. Those who had therapy pre-training showed a higher need to be self-sufficient and a belief that therapy was important for personal and professional development (PPD). The temporal link between attitude and therapy is unspecified. It could be that the effect of therapy led to the development of these attitudes. Perhaps the experience of therapy led trainees to believe they should be thereafter able to solve their own problems, and perhaps manage their emotional experiences independently.

Psychological flexibility scores were lower for those who had therapy pre-training, suggesting higher experiential avoidance. High scores for PPD could reflect that trainees found therapy useful or could be a way of compensating for negative beliefs about the self as "needing" therapy. Trainees who had not had therapy were less judgmental towards themselves. There may be perceived pressure before training about being "good enough" or even "perfect"; use of therapy may not fit into that ideal. These ideas may fit with Bryant's (2008) ideas about maintaining an "illusion of mental health". It may be difficult for those seeking to become part of a profession that is rooted in providing help, to admit that they have needed help to cope with difficult experiences. This is likely to be the case particularly where there is an understanding by self or other (for example a training course) that therapy is problem-focused (Atkinson, 2006).

An alternative explanation is that trainees had developed this attitude through their career prior to starting the course and retained it in the current time. Clinical training sometimes seems to be viewed as the beginning of a clinical psychology career and the beginning of PPD (Hughes and Youngson, 2009); perhaps this

earlier use of therapy connected with positive attitude to therapy for development suggests that people start their PPD journey before this time. This may again be connected to how the purpose of therapy is understood.

Trainee characteristics: Summary

Experiences of abuse and therapy have not previously been discussed in the literature and the prevalence of abuse (and previous therapy) in this population seemed surprising in some ways. How the purpose of therapy is understood by researchers and dominant discourses about the trainee population may have influenced the prevalence of particular questions. It may be that some questions are privileged, and others subjugated. Stress and anxiety has been well-researched in the trainee population (eg, Cushway, 1992; Kuyken, 1998), however abuse has very rarely been discussed. Partington (2009) discussed selection of potential trainees (in South Africa) and found that traumatic life events were not an obstacle, provided that the applicant demonstrated the potential for psychological resolution. On the basis of this idea, perhaps it has seemed risky to ask candidates questions about this or for applicants to disclose abusive histories. Perhaps there are questions about how potential for psychological resolution should be measured fairly, across candidates, in a recruitment process.

Perhaps research in this area has been considered too intrusive or researchers have not wished to play into a stereotype of a “wounded healer”. Perhaps there has been a difficulty in connection to a potentially painful subject. It may also have been difficult for trainees on courses to raise abuse as an issue, for example because of perceived stigma (Coffey, Leitenberg, Henning, Turner and Bennett, 1996), issues around secrecy (Davies and Frawly, 1994) or simply because it has been unclear whether personal issues are up for discussion (Jones, 2009).

Previous therapy may also not be discussed for similar reasons. This is one of the few studies to explicitly consider the impact of previous life experience on trainees. Where these experiences remain overlooked in the literature, it seems possible that development of trainee resilience, ability to manage emotional experience and other aspects of self may not be properly understood. This lack

of understanding may have implications for training and PPD; these aspects of self may be important professionally, as well as personally.

Exploring current use of personal therapy

This study aimed to consider salient discriminators between trainees, who were initially grouped into four groups, which related to stage of decision regarding the use of personal therapy (PT). Trainees' previous experience of therapy was found to be differentially spread across the current therapy groups, and there were differences in attitude to therapy and experience of childhood trauma. These findings led to revision of these groups to three PT groups, which were not considering therapy, actively considering therapy and used/using therapy. Several factors were found to be different across the three groups. These findings will now be discussed.

Demographics and Orientation

The therapeutic orientation of the trainee, the year of training and perceptions of course support for therapy showed differences between the groups.

Most trainees said their orientation included CBT but not psychodynamic thinking. The highest percentage of trainees who were not considering therapy stated this was their therapeutic orientation. Fewest trainees said that their orientation included psychodynamic but not CBT models. Within this group very few said they were not considering therapy. Trainees whose orientation included psychodynamic models but not CBT scored significantly more highly on measures of importance of therapy for PPD. This fits with the position of both models (Stedmon and Dallos, 2009). Psychodynamic models advocate self-relatedness and therapy as a means to achieve this (Orlinsky and Howard, 1980; Thomas, 2004), whereas CBT does not make this suggestion.

Norcross and Prochaska (1983) noted that clinical psychologists choose therapeutic orientation based on personal values, clinical experiences and graduate training. Asking trainees to suggest what is included in their therapeutic orientation might thus be premature; however the fact that they could do this suggests that they are considering how they position themselves professionally. Choices about therapeutic orientation lead to suggestions about how PPD should progress.

Trainees in therapy or who had recently finished were most likely to be in the second year of training. Data collection took place at the end of the academic year; more time in training would have given more opportunities to think about therapeutic orientation and philosophical position, and to act on these developing ideas. It is noted that Cushway (1992) found that there were higher levels of stress and anxiety in the second and third years. This may also be pertinent in the timing of seeking therapy.

There were differences in how connected trainees seemed to be to course support. Those not considering therapy were most likely to not remember the position of the course on which they trained towards personal therapy. Where courses did not speak about personal therapy as a means of PPD, a higher percentage of trainees were not considering therapy. Conversely, a higher percentage of trainees were considering therapy, or were already engaged with therapy, where trainees perceived that courses had spoken about this option. These findings support the work of Jones, (1999) and Dearing et al (2005), who noted that ambiguity in the attitudes of significant others made it more difficult to seek therapy. It may be easier to be connected to the views of important others (eg the course team) when you are in agreement with their views, and when you are interested in the subject. Power issues may be important to consider here.

Perceptions of course attitude to therapy may link with course orientation, which may in turn impact on the type of training provided and clinical experiences offered. These have been shown to relate to the development of one's own therapeutic orientation (Norcross and Prochaska, 1983), which in turn has some impact on the path taken for personal and professional development. It is noted that most courses were reported to include CBT in their thinking; very few were reported as psychodynamic without CBT. This fits with the dominance of CBT in clinical psychology at present; it is likely to be important that training courses equip trainees in the dominant model. Where courses are most strongly orientated towards CBT, this may have implications for the value seen to be attached to personal therapy as a means of PPD.

Intrapersonal factors

Personal and professional development may occur in the realm of self (Hughes and Youngson, 2009), encompassing the known self and unknown self. This considers identity, including issues of diversity. Part of the self may be unknown due to a lack of connectedness; increasing awareness of the unknown self may thus lead to personal and/or professional growth.

In analysis, one discriminant function was shown to differentiate between the groups. This was labelled "development and connectedness", and accounted for more than a third of the variance. This function suggested that those in the therapy group placed a high value on therapy for PPD, but had low scores for psychological flexibility, whereas the converse was true for those not considering therapy. One aim of therapy is to develop self-relatedness (Orlinsky and Howard, 1980); perhaps this need was recognised by trainees who made the choice to use therapy.

Therapy is recognised as a difficult process however, and one that may involve ambivalence at times. Mollera et al (2009) wrote of perceptions among trainees that therapy would be helpful *and* costly. Ideas that it could "open a can of worms" sat alongside thoughts about personal development and growth. Mollera et al's (2009) study among first year trainees may fit with this research which suggested that experiential avoidance and perceived ability to manage internal experiences sits alongside a belief that therapy is important for development.

The decision to use therapy or not may depend on the weight placed on growth vs cost. Prochaska and DiClemente (1994) suggested that people go through stages of change; this study used that idea in grouping participants. Mollera et al's (2008) "can of worms" may be a good analogy to consider how intrapersonal factors may be understood in the groups of participants in this study.

This study showed that those not considering therapy had higher psychological flexibility scores; they were also more self-compassionate and less avoidant in their coping style. Perhaps they felt that they could cope with the worms in the can (ie their internal experience), the worms were in fact not problematic, and that therapy would not assist them. High psychological flexibility denotes access to personal wisdom (Hayes et al, 1996); perhaps worms have been managed before

by trainees in this group and they thus have confidence in their abilities. The participants in this group were also less likely to have experienced emotional neglect, and concurrent invalidation. The impact of this will be discussed more later in this chapter, however it is noted that a more nurturing childhood is likely to have been protective and have led to the development of strategies for managing internal experience flexibly and with compassion for self (Gilbert, 2005). There may be questions about how connected those not considering therapy were to how problematic the worms were and their potential fear. It has been noted that experiential avoidance can be difficult to observe and measure (Hayes et al, 1996).

Conversely, those in therapy may have noticed that they feared opening the can of worms, and thought that personal therapy could help them in dealing with the worms, and also perhaps with their fear. While they had lower psychological flexibility, they had high PPD scores. If therapy is understood by trainees to help improve self-relatedness (Orlinsky and Howard, 1980) and to improve coping skills, then it would make sense for those who felt themselves struggling to manage their internal experience to seek this. Where a lack of self-relatedness or understanding is considered to be impacting on clinical competence, seeking therapy could be framed conceptually in terms of personal and professional development. Where it is difficult for psychologists to accept the aspects of themselves that need help (perhaps because of the role as “helper”), professional validation and framing as development may make seeking therapy easier.

Bryant’s (2008) model, which was developed with qualified clinical psychologists in mind, could be seen to have relevance for trainees. Figure 6 shows Bryant’s (2008) model (previously shown in Figure 3, p. 33), with notes of how this research may add to or clarify factors for the trainee population. The context of training, which by it’s nature requires demonstration of development, suggests that perhaps for trainees the triggers and context box overlap.

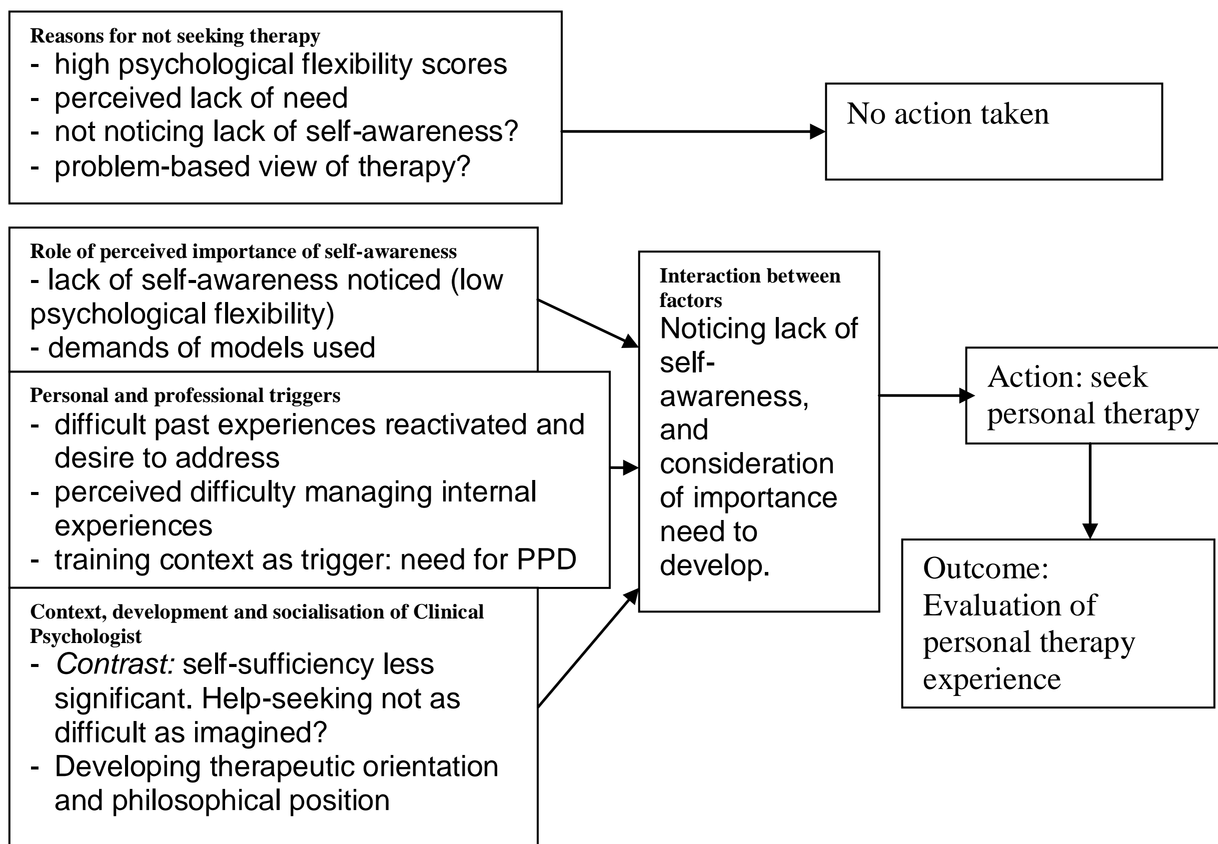

Figure 6: Bryant's (2008) preliminary model of the decision-making process: What influences a Clinical Psychologist's decision to enter personal therapy?

As with all decisions, time is required for a person to move through the stages of change (Prochaska and DiClemente, 1994). Bryant (2008) wrote of the impact of professional triggers in moving people between stages of decision in therapy. In this case, noticing a lack of awareness may occur over months, with a build up of clinical experiences and supervisor's comments. At some point trainees might experience incompetence, or a client's issues could resonate with them in a way that does not feel manageable, or they may notice a failure in themselves to respond to an issue. These experiences, if connected to, may lead them to think differently about how flexible they are psychologically and about the need to develop in specific areas. This may also account for differences in year groups across the PT groups. Training is (at least) a three year endeavour; development will occur throughout this time and, hopefully, thereafter and position on therapy and reflective competence is likely to fluctuate. Trainees may need to consider their resources (internal and external); the perception of the sufficiency of these may shift over time and with growing and/or changing demands.

It is noted that there were no significant differences within PT groups on intrapersonal scores based on experience of abuse. This potentially supports the

idea that the perceived ability to manage emotions and responses to difficult life events, rather than the experiences themselves, are important in decision-making about the use of therapy. The understanding of one's ability to connect with and manage experiences may be mediated by early experiences (Fonagy et al, 2004). Both these factors may be linked with a consideration that therapy is important for PPD.

Interpersonal factors

Personal and professional development may also occur in the realm of self relation to others (Hughes and Youngson, 2009), where the self may be seen or unseen. This is important to hold in mind; the "trainee" may be one part of a broader identity, which may include many other identities not seen by those on the course.

Areas which hold importance, for example experiences of abuse, may not be seen or spoken about but may influence development. The impact of secrecy that is prevalent in abuse (Davies and Frawley, 1994) may mean that it is difficult for trainees to raise this issue, because of past experiences of being unheard, disbelieved or too frightened to speak. The psychological implications for this type of secrecy can be widespread, including potential development of a belief that others do not want to know, or that this experience is shameful and should be "forgotten". This disconnection from experience may be protective, but in the role of therapist may lead to difficulties in building therapeutic alliance, as has been discussed. A lack of disclosure to the training cohort or course may not be problematic where it is possible to gain support elsewhere; courses may need to keep this issue in mind when considering how to facilitate PPD in trainees on their course. Courses may also need to be mindful about how the meaning of their actions may be perceived; perceived failure to create safe spaces to consider issues may seem to collude with trainees' previous experiences of being silenced.

In analysis of interpersonal factors, one discriminant function was shown to differentiate between the three therapy groups. This was labelled "neglected", and accounted for almost a tenth of the variance. This function suggested that those in the therapy group had experiences of neglect, abuse and invalidation, whereas those not considering therapy were positioned at the other end of the

discriminant function. This part of the function was characterised by positive maternal attitude to therapy, whereby mothers were perceived to consider therapy useful.

This is a validating perception for facilitators of therapy. Group means suggested that there were lower abuse, invalidation and neglect scores in the not considering therapy group. Maternal, rather than paternal, attitude and invalidation showed significant differences between the PT groups. It seems possible that the experience of a close bond with a primary care-giver (often mothers) is linked with emotional development.

A perception of validation and nurturing in childhood is likely to be linked to a positive sense of self and perhaps a sense of being able to manage difficulties in adulthood (Bowlby, 1990). Perhaps the knowledge that if help was needed it could be accessed (especially where mothers are positive about therapy), provides a sense of safety which underpins less need for help. It seems from other research that positive interpersonal experiences are important characteristics of those who do not seek personal therapy. Norcross (2008) noted that sufficient social support was the primary reason for not seeking therapy among qualified psychologists. Bryant (2008) supported this through observing that one of the reasons that clinical psychologists sought therapy was the consideration that their usual support was insufficient. Social support in the current time can therefore be seen to be important. It is possible that those who have had positive experiences in childhood may be more able to build support networks and use them (Bowlby, 1990).

Neglect has been shown in this study to be associated with difficulty in developing psychological flexibility and self-compassion. Early developmental experiences (eg of abuse versus safety) often have implications for later intrapersonal experience, thus it could be suggested that Bryant's (2008) model occurs within a developmental and relational framework. Early experiences can influence the values and thinking style of an individual; the impact of these positive and/or negative experiences may be lasting.

Hypothesis testing:

It was suggested that those in therapy would show more self-compassion and more psychological flexibility than those not considering therapy. This was not borne out by the results. Those in the used/using therapy group had the lowest mean psychological flexibility scores of the three groups, with those not considering therapy scoring most highly. This pattern was also seen for self-compassion.

Clinical training may highlight a need for help and/or development for those with difficult histories and/or less flexibility in coping. Personal therapy may be considered as an option to fulfill a need in this area when other resources (internal and external) may not be available or accessible. It may also be useful as an option when the overlap between development and evaluation is perceived as an obstacle to obtaining support directly from the course.

It is possible that noticing a lack of self-relatedness, or connection to experience, may be a trigger for entering therapy; this would account for lower scores. Bryant's (2008) model considered professional triggers in terms of questioning one's competence; this may be relevant for those beginning to consider issues of counter-transference and use of self. It is also noted that therapy may bring a person more into contact with difficult experiences (Orlinsky and Howard, 1980). The struggle to manage emotional responses to these experiences may lead to reduced scores.

It is noted that experiential avoidance is difficult to measure because people may not be aware that they are avoiding difficult issues (Hayes et al, 1996), and therefore score positively. This study would suggest that trainees in the not considering therapy group are psychologically flexible, possibly as a result of nurturing early experiences that allowed them to develop skills in this area. It is also possible, however, that there are some in this group for whom experiential avoidance and disconnection from experience is an issue, but their ability to reflect on this is limited.

Clinical Implications

This study has made a number of observations about the trainee population and how various factors differentiate between those who do and do not use personal

therapy. These findings have implications for the training of clinical psychologists, which is concerned with the personal and professional development of trainees. Findings of this study, and recommendations, may therefore be of interest to training courses and individual trainees. Training courses are responsible for promoting PPD and providing opportunities for growth; trainees must engage with PPD, and make decisions about which methods to use.

The current dominance of CBT in clinical psychology, and perceived dominance of CBT in training course orientation, is likely to have an impact on recommended and validated routes to personal and professional development. CBT does not advocate personal therapy for PPD; it suggests that self-practice and supervision are appropriate methods of development (Bennett-Levy, 2005). CBT takes a problem-based view of therapy; it is unclear how it views therapists who may have problems. If having a problem is considered to make a person deficient in some way, it may make it very difficult for a trainee (who is being evaluated) to admit or connect to areas in which there is a lack (Thomas, 2004). This may include difficulties with relational patterns based on previous experiences, which may be relevant clinically (Levitt, 1991). This viewpoint may inhibit trainees from using therapy in order to solve problems or to develop (although it does not always seem to have this effect). It may also inhibit trainees from discussing their use of therapy, or perpetuate silence about difficult subjects.

All models of therapy have views on therapist use of self, which seems central in the task of personal and professional development. Use of self may include the ability to use one’s own experience of what is useful therapeutically, to monitor one’s responses and use them appropriately in sessions and to be authentic (Wosket, 1999). This requires technical skills that may be practised and an understanding of one’s own position. This position is likely to be informed by life experience, which is in turn influenced by our position within society and our family. Awareness of the limits of our experience will also necessarily be part of this understanding about self. Personal and professional development may then need to be concerned with aspects of practitioners’ lives in and outside of work, and to allow new experiences and skills to emerge, be evaluated and assimilated. Different therapeutic orientations may place different weight on personal and professional aspects. The training course may not always be the best place to

explore issues due to the overlap between development and evaluation; there may be other options with which it seems more straightforward to engage.

This study suggests that there are a number of trainees who have experienced severe childhood abuse, and that this experience is linked with the view that therapy is important for PPD. Therapy is often considered to be a different experience of an attachment relationship (Winnicott, 1965). Personal therapy would therefore perhaps be especially important for trainees without positive attachment figures, as becoming a therapist requires an understanding of how to engage someone in a containing relationship. Those without the experience of containment in childhood may consider that therapy is an opportunity to learn about the feeling of being contained, and how to provide that for others (Thomas, 2004). This is perhaps an example of what Norcross (2005) referred to as the integration of technical competence and personal growth.

The link found between psychological flexibility and PPD scores was interesting. Perhaps a key issue is the ability to notice where connectedness and awareness is lacking. A lack of awareness may be difficult to admit to, particularly where one is being evaluated. The step after noticing the lack is to address this. This may not always seem possible in the training course arena; Jones (2009) wrote of uncertainty among trainees that personal issues were up for discussion with course staff. It may not seem desirable to speak to those evaluating competence about these issues; it may not seem desirable to address a difficulty at all because of fear of change. Where trainees consider an issue important to address, but do not want to do this in the training context (eg through reflective groups or essays), therapy may be an important opportunity for development and growth.

Recommendations:

From the findings of this study, the following suggestions are made:

- Training courses should be explicit in providing opportunities for trainees to notice areas in which they lack self-awareness and understanding. Encouragement to remain in contact with this lack rather than engage in experiential avoidance, and to then address deficits, should be given. These are perhaps important first steps towards growth.

- Courses should be mindful that trainees may have had difficult early relationships, and may need support to recognise and address patterns of relating which are professionally unhelpful.
- All training courses should talk about personal therapy as a potential means of PPD. Not talking about it may suggest to trainees that personal therapy is not appropriate or valued by the course.
- Trainees who demonstrate high levels of self-relatedness may not consider that personal therapy would be useful to them, however they still need to demonstrate development in reflective and reflexive skills. Trainees and courses need to consider how this might be done.

Limitations of the study:

This study used a cross-sectional design and thus provided a view of a trainee cohort at a particular point in time. The research considered trainees' current use of personal therapy; it is acknowledged that this may change over the three years. It is not possible from this research to consider whether views, attitudes and behaviours change. It is also not possible to suggest any causal links between intrapersonal and/or interpersonal factors and the use of personal therapy. Use of therapy may lead to changes in attitude as much as attitude may lead to an increased likelihood that therapy may be sought or considered as an option. Conducting longitudinal research with trainees would be the only way to address this issue.

This study is not able to comment reliably on the use of therapy among trainees pre-training and whether/how this may be related to PPD within a career in Clinical Psychology. The high number of respondents who had used therapy prior to training may lead to questions about sample bias; the low response rate makes it difficult to answer these. Questions were not asked about the purpose of therapy or its effects, or whether the therapeutic relationship had continued into training. While there are difficulties with asking questions retrospectively about attitudes, not asking the questions meant that there was a lack of understanding, and that ultimately a proportion of the sample needed to be excluded from further analysis.

Similarly, while it was possible to consider attitudes towards therapy in terms of PPD, the overlap between personal and professional remains unclear. The study

did not ask trainees to define what therapy was for, or how they understood PPD. These issues may be linked. Not defining trainee position on the purpose of therapy allowed for uncertainty among participants. It did not, however, allow exploration of developing philosophical positions that may have been held by trainees or consider how this related to their current use of personal therapy. It may have been possible to directly ask trainees what they thought therapy was for, and how this applied to them, in their position as a provider of therapy, as a learner in this role, and as a person who faced stressful life and professional events.

The variables chosen did not allow for exploration of the concept of PPD. While this was not the aim of the study, the concept remains somewhat unclear. While this is so, perhaps the value/purpose of PPD is also unclear. The variables focused on familial interpersonal relationships, however in this age group, the relationship between partners may have been a more valid measure of significant other. Considerations about fatigue effects led to interesting variables being left out; the understanding of the impact of interpersonal relationships in choices about personal therapy posited in this study is necessarily incomplete.

The quantitative methodology had advantages and disadvantages. Using several questionnaires may have led to a fatigue effect, which may have led to drop out or sporadic responding. It also meant that exploration of individual views was more difficult. Some trainees chose to send comments, and noted that they felt that things were not explored in sufficient depth or that things were lost in translation through the use of standardised instruments. The opposing argument is that more trainees were able to be involved in this type of study, leading to improved generaliseability, and that using standardised measures provides greater robust-ness, replicability and reliability of interpretation. Given that there are so few studies with British trainees, it seemed sensible to encourage a large sample and from this to develop further questions. While the response rate for this study is not impressive (25%), it corresponds with other studies in this area and provided sufficient power to demonstrate differences between groups of trainees.

There have been some concerns in the literature about response rates in relation to studies with web-based methodologies, particularly with regard to self-selection

biases (Eysenbach and Wyatt, 2002). There are also concerns about the methodology as less accessible to some participants than others, for technical and demographic issues (Schleyer and Forrest, 2000). Other studies have, however, rebutted these arguments (Gosling, Vazire, Srivastava and John, 2004). They suggest that web-based studies may gain more diverse study samples, have better response rates and may be as robust as studies using traditional methods. This suggests that a web-based methodology was the most appropriate means of delivering the questionnaires to a population that is highly computer literate and spends significant time online.

Suggestions for Future Study

There are ongoing difficulties in understanding what is meant by personal and professional development. Whether there is more emphasis on either part of the self, whether this emphasis changes over time and how the two parts overlap may be areas for further research. How psychologists understand the need for personal growth as relevant to their professional role, and whether their relationships with others form part of this may also be areas for further consideration.

While KSF requires evidence of development at all stages of the career, including for assistant psychologists, there does not seem to be any research into the PPD journey prior to clinical training. Anecdotally, there is a huge amount of planning and thinking about how to progress in a career in clinical psychology that occurs before gaining a place on a training course. These experiences are not considered in the literature and trainees may be seen as being at the very beginning of a career. While, in many ways they are, it seems that in other ways, they may not be. This study demonstrated that a significant proportion of trainees had used therapy before beginning training, and that this was linked to an attitude that therapy is important for PPD. How can PPD be described as a journey if its beginnings are not properly understood? Future research may usefully consider how to access the thinking of those before clinical training; prospective or longitudinal research may be a way to tackle this subject and would give insight into the route into the profession. Equally, this study provided a view of how trainees used therapy at one point in time. This may change, and future study into the changing attitudes and use of therapy among trainees may provide deeper insight into PPD during training.

Comments from participants sometimes suggested that there was insufficient opportunity for them to explain the reasoning behind choices. A qualitative study could usefully explore how trainees view their use of personal therapy; its purpose and how they came to choose to use it or not. This could explore findings that therapy for PPD is especially important to those who notice a lack of awareness or self-relatedness. How they understand and came to notice this lack of self-relatedness could also be explored. It would also be interesting to consider how those not considering therapy view their PPD path; what opportunities they have valued and found most useful

Conclusions:

This study, in its aim to understand the trainee population better, has made some seemingly surprising discoveries about the previous life experiences of trainee clinical psychologists. These were particularly in terms of experiences of abuse and therapy.

This study has added to the current understanding about the decision to use personal therapy or not among clinical psychologists, in the training phase of their career. The study found that attitude about the importance of therapy for personal and professional development is important in differentiating between those who do and do not use therapy. These attitudes may be informed by therapeutic orientation, and other values. If PPD is thought about in terms of a growing awareness of who we are, including in relation to others, then self-connectedness is at the heart of development. This study suggests that trainees who struggle with self-connectedness, may believe that therapy will help them to develop these and other skills important for the fulfilment of their professional role.

This study has considered interpersonal factors in the process of PPD, outside of the course for the first time. Interpersonal factors, including emotional neglect, are linked to the way we prioritise relationships, connectedness with self and other, and how easy or dangerous connectedness seems. Where there is a lack of nurturance in childhood, and emotional needs are not met, it is difficult to learn to self-nurture and soothe (Bion, 1976) or to place trust in others to meet needs (Hildyard and Wolfe, 2002). It may be difficult in later life to be connected to

difficult experiences, perhaps because it is believed that painful feelings cannot be contained by the self or by others. This ability to connect with difficult experiences (psychological flexibility) seems, in this study, to be linked with decisions trainees make about personal and professional development, in this case in terms of therapy use.

Those who use therapy report struggling with connectedness more than those who are not considering therapy; part of their developmental journey towards personal growth and use of self is likely to be about self-relatedness. Those not considering therapy report being more connected to the self, however, this does not mean that no development is required. The methods they use for PPD will need to draw on these abilities to allow greater reflection and reflexion on practice. By understanding the differences between those who do and do not use personal therapy during training, one method of PPD is better understood. This may support courses and trainees in thinking about how PPD can be facilitated. Personal and professional development may begin in training, or even before this, but it continues throughout a clinical psychologist's career.

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Revised (September 2005)

SCHOOL OF PSYCHOLOGY ETHICS COMMITTEE APPROVAL

Student Investigator: Amy Duncan

Title of project: Intra- and interpersonal factors in the use of Personal Therapy during training to become a clinical psychologist.

Supervisor: Saskia Keville

Registration Protocol Number: PSY/04/10/AD

The approval for the above research project was granted on 29 April 2010 by the Psychology Ethics Committee under delegated authority from the Ethics Committee of the University of Hertfordshire.

Signed:

Date: 29 April 2010

Professor Lia Kvavilashvili
Chair
Psychology Ethics Committee

STATEMENT OF THE SUPERVISOR:

From my discussions with the above student, as far as I can ascertain, s/he has followed the ethics protocol approved for this project.

Signed (supervisor):

Date: 10.6.11

APPENDIX B1: Initial Letter to Courses

Date
Dear.....
I am a second year trainee clinical psychologist at the University of Hertfordshire. I am investigating intra- and interpersonal factors in the use of personal therapy 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 truly 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, and I am interested in the differences between those who do pursue therapy and those who are not currently considering this option. This seems timely; there is increased emphasis on reflective and reflexive practice within the profession, and consequently in training.
Most of the studies in this field are American, which makes their generaliseability to British trainees questionable. Research thus far has focused on cognitive aspects of choices and the influence of course attitude to therapy. I would like to extend this focus to consider the impact of the attitude of significant others and perceived stigma, and to consider issues of emotional connectedness, self-care and coping style. It seems to me that trainees may need, like anyone else, to seek support at stressful times, and I hope that this research will promote discussion about what makes therapy (as one potential form of support and development) more or less accessible.
This study has received ethics approval from University of Hertfordshire ethics committee (registration no: PSY/04/10/AD). Trainees will need to fill in an online survey, asking them about their attitudes, coping style and connectedness, their perceptions of the support for therapy from others and stigma. They will not be asked to identify the course on which they train, or for any personal information, other than age and gender, making responses 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 a link to the survey. 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 A.Duncan@herts.ac.uk.
Many thanks,

Amy Duncan
Trainee Clinical Psychologist
University of Hertfordshire

Supervised by: Dr Saskia Keville, University of Hertfordshire.

APPENDIX B2: Letter of invitation to Trainees (sent in email)

22.05.10

Dear Trainee,

I am writing to invite you, and all the other trainees in the UK, to participate in my Major Research Project. I am investigating the intra and interpersonal factors that influence the use of personal therapy during training as a means of 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, and I am interested in the differences between those who do pursue therapy and those who are not currently considering this option. This seems timely; there is increased emphasis on reflective and reflexive practice within the profession, and consequently in training.

You will need to fill out a number of questionnaires on various measures, such as coping style, self-care, perceptions of support from others, etc. There is more detailed information in the attached information sheet. All years are invited to participate. The survey should take no more than 30 minutes to complete. No-one will be asked to identify the course on which they train. I am really hoping that trainees throughout the UK will see this study as an opportunity to express their views on this subject, and add to the debate about the use of personal therapy. My course mates have said that it has been interesting and thought-provoking to complete, and I really hope that you will feel the same.

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. The link to the study is below, and on the information sheet.

Many thanks,
Amy Duncan
Trainee Clinical Psychologist
University of Hertfordshire

LINK to study:
http://www.surveymonkey.com/s/QVHZPSG

APPENDIX B3: Reminder letter to Trainees (sent in email)

02.09.10

Dear Trainee,

I am writing to invite you, and all the other trainees in the UK, to participate in my Major Research Project. I wrote to you earlier in the summer and just wanted to remind you that I am collecting data now! The deadline for completing the survey is the 4th October 2010; please complete it before then if you would like to participate.

I am investigating the intra and interpersonal factors that influence the use of personal therapy during training as a means of 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, and I am interested in the differences between those who do pursue therapy and those who are not currently considering this option. This seems timely; there is increased emphasis on reflective and reflexive practice within the profession, and consequently in training.

You will need to fill out a number of questionnaires on various measures, such as coping style, self-care, perceptions of support from others, etc. There is more detailed information in the attached information sheet. All years are invited to participate. The survey should take no more than 30 minutes to complete. No-one will be asked to identify the course on which they train. I am really hoping that trainees throughout the UK will see this study as an opportunity to express their views on this subject, and add to the debate about the use of personal therapy. My course mates have said that it has been interesting and thought-provoking to complete, and I really hope that you will feel the same.

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. The link to the study is below, and on the information sheet.

Many thanks,
Amy Duncan
Trainee Clinical Psychologist
University of Hertfordshire

LINK to study:
http://www.surveymonkey.com/s/QVHZPSG

APPENDIX B4: Information Sheet sent with letters

INFORMATION SHEET FOR PARTICIPANTS.

Introduction
Trainee Clinical Psychologists in the UK are being invited to participate in a study investigating the use of personal therapy while training. This information sheet aims to give you details about how and why the research is being carried out. Please take a few minutes to read it through before you decide whether to give consent to participate.

The researchers
The study is being carried out by Amy Duncan, Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology. The study is supervised by Dr Saskia Keville, Clinical Lecturer and Chartered Clinical Psychologist, and Dr Pieter Nel, Clinical Lecturer and Chartered Clinical Psychologist.

What is the purpose of the study?
Personal therapy is one method of increasing reflective skills as part of personal and professional development, but is not mandatory for clinical psychology trainees. Some trainees use this tool, whereas others do not; all trainees need to develop therapeutic and reflective skills. This study aims to investigate intra personal and inter personal factors associated with the use or non-use of personal therapy during training.

What is involved?
Participants will need to fill out an online survey, the link to which is at the end of this information sheet. Questions will be asked about demographic information (age and gender), therapeutic orientation, coping style, your attitude towards therapy and that of your family. There are also questions about how accepting and self-caring you are, about stigma and about any difficulties you experienced in childhood. These questions aim to tap into various intrapersonal and interpersonal factors that may have impacted on your choice to use personal therapy or not during training.

Who is taking part?
All trainees in the UK have been invited to participate, as I would like to get a really representative sample of what factors impact on choices people make during clinical training about their personal and professional development. Obviously, the more trainees who participate, the better my understanding will be. I hope that at least 200 trainees will take the time to fill out the survey.

Do I have to take part?
No. If you do not want to participate, you do not have to, and you are free to withdraw at any time. This will not affect your training in any way, and you will not be asked to identify the course on which you train.

What do I have to do?
If you would like to participate, please follow the link to the online survey. You will need to fill out the online consent form, and then answer a series of questions. There are nine areas I hope to cover; this should not take more than 30 minutes.

Will taking part be confidential?

Yes. I will not ask you for your name, or for the name of your course. The responses will go into a database as a number, and responses will be accessible to the researchers only.

What are the benefits of taking part?
Clinical Psychology is moving towards a reflective-practitioner, as well as scientist-practitioner model. It would be useful to have increased understanding about the factors associated with the use of different paths towards developing these skills.
Participants are invited to email me for a copy of the results May-July 2011.

What if I have questions or concerns?
If you have any further questions about the research, please feel free to contact the researcher via email, details of which are below. In the unlikely event that participating in this research has caused you distress in some way, please do not hesitate to contact the researcher who will be able to advise you on where you may be able to access further help. There will also be information about where to get support at the end of the survey.

Who has reviewed this study?
The study has been reviewed and approved by the University of Hertfordshire Psychology Ethics Committee. Protocol number PSY/04/10/AD.

Thank you for taking time to read this.

Contact details of the researcher:
Amy Duncan
Email address: **A.Duncan@herts.ac.uk**

May 2010

LINK TO SURVEY: Please copy this into your browser window. The link also appears on the email you received.

http://www.surveymonkey.com/s/QVHZPSG

Appendix C: Questionnaire pack (Base for survey monkey)
Weblink: http://www.surveymonkey.com/s/QVHZPSG

Consent questions

1. I confirm that I have read and understood the information sheet (dated May 2010) for the study. I have had the opportunity to consider the information and if needed ask questions that were satisfactorily answered

- Yes
- No

2. I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason.

- Yes
- No

3. I agree to take part in the above study

- Yes
- No

Default section:

Gender:
- Male
- Female

Age:
- 21-26
- 27-32
- 33-38
- 39-44
- 45-50
- Older than 50

Year on course
- 1st
- 2nd
- 3rd

Your own therapeutic orientation:
- CBT
- Behavioural
- Social constructionist
- Other systemic
- Psychodynamic
- Humanistic
- Other (please state)

Course orientation:
- CBT
- Behavioural
- Social constructionist
- Other systemic
- Psychodynamic
- Humanistic
- Other (please state)

How good is the fit between your own therapeutic orientation and that of the course?
Scale 1-5 (Very good – Very poor)

Have you had psychotherapy before the start of the course for any reason?
- Yes
- no

How would you describe your current use of personal therapy?

- Not considering it
- Actively considering it
- In therapy
- Recently ended therapy

Has your course spoken about PT as a method of personal and professional development:

- yes
- no
- don't remember

Does your course provide financial support for personal therapy?

- Yes
- No
- Don't know

Is there anyone on your course (eg a tutor) who might provide support in finding a therapist?

- Yes
- No
- Not sure

Brief COPE

These items deal with ways you cope with the stress in your life. There are many ways to try to deal with problems. Obviously, different people deal with things in different ways, but I'm interested in how you try to deal with problems. Each item says something about a particular way of coping. I want to know to what extent you generally do what the item says when you have a problem or are feeling stressed. How much or how frequently you do this. Don't answer on the basis of whether it seems to be working or not—just whether or not you do it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1	2	3	4
I never do this at all	I do this a little bit	I do this a medium amount	I do this a lot

1. I turn to work or other activities to take my mind off things.
2. I concentrate my efforts on doing something about the situation I'm in.
3. I say to myself "this isn't real.".
4. I use alcohol or other drugs to make myself feel better.
5. I get emotional support from others.
6. I give up trying to deal with it.
7. I take action to try to make the situation better.
8. I refuse to believe that it has happened.
9. I say things to let my unpleasant feelings escape.
10. I get help and advice from other people.
11. I use alcohol or other drugs to help me get through it.
12. I try to see it in a different light, to make it seem more positive.
13. I criticize myself.
14. I try to come up with a strategy about what to do.
15. I get comfort and understanding from someone.
16. I give up the attempt to cope.
17. I look for something good in what is happening.
18. I make jokes about it.
19. I do something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I accept the reality of the fact that it has happened.
21. I express my negative feelings.
22. I try to find comfort in my religion or spiritual beliefs.
23. I try to get advice or help from other people about what to do.
24. I learn to live with it.
25. I think hard about what steps to take.
26. I blame myself for things that happened.
27. I pray or meditate.
28. I make fun of the situation.

Acceptance and Avoidance

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
Never true	**Very seldom true**	**Seldom true**	**Sometimes true**	**Frequently true**	**Almost always true**	**Always true**

Statement							
1. It's OK if I remember something unpleasant.	1	2	3	4	5	6	7
2. My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
3. I'm afraid of my feelings.	1	2	3	4	5	6	7
4. I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
5. My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7
6. I am in control of my life.	1	2	3	4	5	6	7
7. Emotions cause problems in my life.	1	2	3	4	5	6	7
8. It seems like most people are handling their lives better than I am.	1	2	3	4	5	6	7
9. Worries get in the way of my success.	1	2	3	4	5	6	7
10. My thoughts and feelings do not get in the way of how I want to live my life.	1	2	3	4	5	6	7

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. Please indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

I behave like this:

1. I'm disapproving and judgmental about my own flaws and inadequacies.
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I'm feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm intolerant and impatient towards those aspects of my personality I don't like.
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don't like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
19. I'm kind to myself when I'm experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down I try to approach my feelings with curiosity and openness.
23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.

TRAINEE ATTITUDE

Please read each statement and decide whether or not you agree with it.

1	2	3	4	5
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

I think that:

11. Psychologists should be able to resolve their personal problems on their own
12. I would feel very uneasy seeking personal therapy for myself because of what some people would think
13. Going through one's own psychotherapy is important for a psychologist's professional growth
14. Seeking psychotherapy would damage my credibility as a therapist
15. Undergoing my own psychotherapy would enhance my ability as a psychologist
16. A competent psychologist should be able to use his/her skills to solve his/her own psychological problems
17. In order to help others, psychologists need to address their own issues through psychotherapy
18. If I were to seek psychotherapy for myself, my colleagues would see me as incompetent.
19. Seeking psychotherapy would make me a stronger therapist
20. Seeking psychotherapy for myself could ruin my chances for a successful career
21. It is important to me that I be able to solve my personal problems on my own
22. Seeking psychotherapy is an important part of a psychologist's personal and professional growth
23. I would not trust a psychologist who has sought psychotherapy for his/her own problems
24. Psychologists who undergo psychotherapy make better therapists than those who don't
25. Graduate programs in psychology should not accept students who have a history of seeking psychotherapy
26. If I were to seek psychotherapy for myself, my colleagues would see me as weak
27. It is the ethical responsibility of psychologists to seek help if they are having problems
28. Psychologists should at least be able to deal with minor problems on their own
29. If I were to seek psychotherapy for myself, I would be afraid that I might be "found out"
30. I would be embarrassed if I were to come into contact with a former therapist of mine in the workplace
31. If I were to seek psychotherapy, I would gladly let my classmates know about it
32. It should be mandatory for all counseling/clinical psychology students to undergo therapy as part of training.

Stigma: Self-stigma

Please read each statement and decide whether or not you agree with it.

1	2	3	4	5
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

1. I would feel inadequate if I went to a therapist for psychological help
2. My self-confidence would **not** be threatened if I sought professional help
3. Seeking psychological help would make me feel less intelligent
4. My self-esteem would increase if I talked to a therapist
5. My view of myself would not change just because I made the choice to use a therapist
6. It would make me feel inferior to ask a therapist for help
7. I would feel okay about myself if I made the choice to seek professional help
8. If I went to a therapist I would be less satisfied with myself
9. My self-confidence would remain the same if I sought help for a problem I could not solve
10. I would feel worse about myself if I could not solve my own problems.

Social stigma:

Please consider people you know from the cultural group with which you identify.

1. Imagine you had an academic or vocational issue you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that these people would:

1	2	3	4	5
Not at all	A little	Some	A lot	A great deal

1. react negatively to you
2. think bad things of you
3. see you as seriously disturbed
4. think of you in a less favourable way
5. think you posed a risk to others

2. It would be helpful if we knew which cultural group you identify with most closely. Please state this below:

3. It would be helpful if we knew which religious group you identify with most closely. Please state this below:

4. It would be helpful if we knew which socio-economic group you identify with most closely. Please state this below:

Attitudes of others: family of origin

Please answer this based on your perception of what your mother/maternal care-giver thinks about seeking psychological help for herself.

1. How my mother* would feel about seeking psychological help for herself

* or maternal care-giving figure

0	1	2	3
Disagree	Partly disagree	Partly agree	Agree

1. If my mother* believed she were having a mental breakdown, her first inclination would be to get professional help
2. The idea of talking about problems with a psychologist strikes my mother* as a poor way to get rid of emotional conflicts
3. If my mother* was experiencing a serious emotional crisis at this point in her life, she would be confident that she could find relief in psychotherapy.
4. My mother* thinks that there is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears *without* resorting to professional help
5. My mother* would want to get psychological help if she were worried or upset for a long period of time
6. My mother* might want to have psychological counseling in the future
7. My mother* thinks that a person with an emotional problem is not likely to solve it alone; but that he/she *is* likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, my mother* thinks that it would have doubtful value for a person like her.
9. My mother* thinks that a person should work out his/her own problems; getting psychological counseling should be a last resort.
10. My mother* thinks that personal and emotional troubles, like many things, tend to work out by themselves.

Attitudes of others: family of origin

Please answer this based on your perception of what your father/paternal care-giver thinks about seeking psychological help for himself.

1. How my father* would feel about seeking psychological help for herself

* or paternal care-giving figure

0	1	2	3
Disagree	Partly disagree	Partly agree	Agree

1. If my father* believed he were having a mental breakdown, his first inclination would be to get professional help
2. The idea of talking about problems with a psychologist strikes my father* as a poor way to get rid of emotional conflicts
3. If my father* was experiencing a serious emotional crisis at this point in his life, he would be confident that he could find relief in psychotherapy.
4. My father* thinks that there is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears *without* resorting to professional help
5. My father* would want to get psychological help if he were worried or upset for a long period of time
6. My father* might want to have psychological counseling in the future
7. My father* thinks that a person with an emotional problem is not likely to solve it alone; but that he/she *is* likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, my father* thinks that it would have doubtful value for a person like him
9. My father* thinks that a person should work out his/her own problems; getting psychological counseling should be a last resort.
10. My father* thinks that personal and emotional troubles, like many things, tend to work out by themselves.

Childhood Traumas

These questions ask about some of your experiences growing up as a child and a teenager. Although some of these questions are of a personal nature, please try to answer as honestly as you can.

1	2	3	4	5
Never true	Rarely true	Sometimes true	Often true	Very often true

When I was growing up:

1. I didn't have enough to eat
2. I knew that there was someone to take care of me and protect me
3. People in my family called me things like "stupid", "lazy" or "ugly"
4. My parent/carers were too drunk or high to take care of the family
5. There was someone in my family who helped me feel that I was important or special
6. I had to wear dirty clothes
7. I felt loved
8. I thought that my parent/carers wished I had never been born
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital
10. There was nothing I wanted to change about my family
11. People in my family hit me so hard that it left me with bruises or marks
12. I was punished with a belt, a board, a cord or some other hard object
13. People in my family looked out for each other
14. People in my family said hurtful or insulting things to me
15. I believe that I was physically abused
16. I had the perfect childhood
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour or doctor
18. I felt that someone in my family hated me
19. People in my family felt close to each other
20. Someone tried to touch me in a sexual way, or tried to make me touch them
21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them
22. I had the best family in the world
23. Someone tried to make me do sexual things or watch sexual things
24. Someone molested me
25. I believe I was emotionally abused
26. There was someone to take me to the doctor if I needed it
27. I believe that I was sexually abused
28. My family was a source of strength and support.

Invalidating childhood environment scale

The following questions address your experiences of how your parent(s)/carer(s) responded to your emotions when you were young. For each item, please choose the rating from 1 to 5 that most closely reflects your experience up to the age of 18years.

1	2	3	4	5
Never	Rarely	Some of the time	Most of the time	All of the time

My mother/maternal care-giving figure:

1. My mother would become angry if I disagreed with her.
2. When I was anxious, my mother ignored this.
3. If I was happy, my mother would be sarcastic and say things like: “What are you smiling at?”
4. If I was upset, my mother said things like: “I'll give you something to really cry about!”
5. My mother made me feel OK if I told her I didn't understand something difficult the first time.
6. If I was pleased because I had done well at school, my mother would say things like: “Don't get too confident”.
7. If I said I couldn't do something, my mother would say things like: “You're being difficult on purpose”.
8. My mother would understand and help me if I couldn't do something straight away.
9. My mother used to say things like: “Talking about worries just makes them worse”.
10. If I couldn't do something however hard I tried, my mother told me I was lazy.
11. My mother would explode with anger if I made decisions without asking her first.
12. When I was miserable, my mother asked me what was upsetting me, so that she could help me.
13. If I couldn't solve a problem, my mother would say things like: “Don't be so stupid — even an idiot could do that!”
14. When I talked about my plans for the future, my mother listened to me and encouraged me.

Invalidating childhood environment scale

The following questions address your experiences of how your parent(s)/carer(s) responded to your emotions when you were young. For each item, please choose the rating from 1 to 5 that most closely reflects your experience up to the age of 18years.

1	2	3	4	5
Never	Rarely	Some of the time	Most of the time	All of the time

My father/paternal care-giving figure:

15. My father would become angry if I disagreed with him.
16. When I was anxious, my father ignored this.
17. If I was happy, my father would be sarcastic and say things like: “What are you smiling at?”
18. If I was upset, my father said things like: “I'll give you something to really cry about!”
19. My father made me feel OK if I told him I didn't understand something difficult the first time.
20. If I was pleased because I had done well at school, my father would say things like: “Don't get too confident”.
21. If I said I couldn't do something, my father would say things like: “You're being difficult on purpose”.
22. My father would understand and help me if I couldn't do something straight away.
23. My father used to say things like: “Talking about worries just makes them worse”.
24. If I couldn't do something however hard I tried, my father told me I was lazy.
25. My father would explode with anger if I made decisions without asking him first.
26. When I was miserable, my father asked me what was upsetting me, so that he could help me.
27. If I couldn't solve a problem, my father would say things like: “Don't be so stupid — even an idiot could do that!”
28. When I talked about my plans for the future, my father listened to me and encouraged me.

Factors in the use of personal therapy during training to become a clinical psychologist

Thank you very much for taking part!

This study aimed to consider differences between trainees in therapy and those not considering it at present in terms of intra- and inter-personal factors.

The intrapersonal factors considered were emotional connectedness, self-compassion (as a measure of self-care), coping style and personal attitude to therapy. The interpersonal factors considered were perceived attitude of others towards therapy. These were people in the system around you, namely your training course, your family of origin, and the cultural group with which you most closely identify. We also looked into the effect of difficulties in childhood and adolescence.

It is hoped that this research will provide more understanding about personal and professional development issues.

If you would like to see the final report of the study, please email me at A.Duncan@herts.ac.uk, and I will ensure that a copy reaches you in due course.

I hope that participating in this research was an interesting experience. If you have further questions, or would like to discuss things further, please feel free to contact me at the above email address, with a telephone number if you wish, and I will get back to you as soon as possible. Alternatively, your personal tutor may be able to provide some support if you feel you would like to discuss anything raised by this study.

Organisations that may be able to provide support include:

NAPAC: The National Association for People Abused in Childhood
0800 085 3330
www.napac.org.uk/

Samaritans: 08457 90 90 90; jo@samaritans.org0 90

Thanks again!

Appendix D: Additional Information on the Data

Table D1: number of Scales meeting criteria for moderate/severe abuse considering missing values.

		Frequency	*Percent*
Missing Subscales	0 scales	71	16.2
Moderate or Severe Abuse with no missing subscales	0 scales	251	57.4
	1 scale	63	14.4
	2 scales	21	4.8
	3 scales	14	3.2
	4 scales	4	0.9
	5 scales	4	0.9
Moderate or Severe Abuse with one missing subscale	1 scale	7	1.6
	2 scales	1	.2
	4 scales	1	.2
Total		437	100

Table D2: Correlations of abuse scores.

	Emotional Abuse	*Sexual Abuse*	*Emotional Neglect*	*Physical Neglect*
Physical Abuse	0.42**	.12*	.29**	.26**
Emotional abuse		.19**	.64**	.48**
Sexual Abuse			.16**	.13*
Emotional Neglect				.61**

** significant at *p*=0.01, * significant at *p*=0.05.

Table D3: Trainees experience of emotional abuse where there was physical abuse.

	None/ Minimal Physical Abuse	*Low/ Moderate Physical Abuse*	*Moderate Physical Abuse*	*Severe/ Extreme Physical Abuse*	*Total*
None/Minimal Emotional Abuse	222 (67%)	4 (20%)	2 (20%)	1 (10%)	229
Low/Moderate Emotional Abuse	75 (23%)	2 (10%)	1 (10%)	3 (30%)	81
Moderate Emotional Abuse	19 (6%)	5 (25%)	3 (30%)	0 (0%)	27
Severe/Extreme Emotional Abuse	14 (4%)	9 (45%)	4 (40%)	6 (60%)	33
Total	330 (100%)	20 (100%)	10 (100%)	10 (100%)	370

Table D4: Trainees experience of emotional abuse where there was sexual abuse

	None/ Minimal Sexual Abuse	*Low/ Moderate Sexual Abuse*	*Moderate Sexual Abuse*	*Severe/ Extreme Sexual Abuse*	*Total*
None/Minimal Emotional Abuse	219 (64%)	4 (40%)	4 (40%)	6 (46%)	233
Low/Moderate Emotional Abuse	72 (21%)	3 (30%)	2 (20%)	2 (15%)	79
Moderate Emotional Abuse	26 (8%)	1 (10%)	1 (10%)	0 (0%)	28
Severe/Extreme Emotional Abuse	23 (7%)	2 (20%)	3 (30%)	5 (39%)	33
Total	340 (100%)	10 (100%)	10 (100%)	13 (100%)	373

Table D5: Therapy pre-training where there was moderate/severe abuse

		Number of subscales meeting criteria for Moderate/Severe abuse						
		.00	1.00	2.00	3.00	4.00	5.00	Total
Therapy pre-training	Yes	75 (23%)	28 (40%)	11 (52%)	7 (47%)	3 (60%)	2 (50%)	126
	No	247 (77%)	42 (60%)	10 (48%)	8 (53%)	2 (40%)	2 (50%)	311
Total		322 100%	70 100%	21 100%	15 100%	5 100%	4 100%	437 100%

Table D6: Descriptive statistics on intrapersonal variables where trainees have/have not experienced emotional abuse

	Emotional Abuse	N	Mean	Std. Deviation	Std. Error Mean
Nonavoidcoping	no	233	5.6159	.98232	.06435
	yes	62	5.4919	1.07311	.13629
Avoidcoping	no	230	4.4623	.58675	.03869
	yes	62	4.5941	.53614	.06809
Attitude towards Personal Therapy	no	225	76.62	7.723	.515
	yes	61	79.66	7.552	.967
Selfsufficiency	no	234	2.7062	.65221	.04264
	yes	62	2.4435	.68565	.08708
PPD	no	230	5.6125	.74903	.04939
	yes	62	6.1371	.64047	.08134
Acceptance	no	230	54.04	7.972	.526
	yes	61	48.82	9.873	1.264
Self-Compassion	no	218	3.2772	.64747	.04385
	yes	59	3.0183	.67380	.08772
Selfkindness	no	229	3.2105	.77814	.05142
	yes	61	3.0525	.77106	.09872
Selfjudgement	no	232	3.1431	.93783	.06157
	yes	61	2.7180	.91388	.11701

Table D7: Descriptive statistics on intrapersonal variables where trainees have/have not experienced emotional neglect

	Emotional Neglect	N	Mean	Std. Deviation	Std. Error Mean
Nonavoidcoping	No	224	5.6719	.99355	.06638
	yes	57	5.3421	1.04863	.13889
Avoidcoping	no	219	4.5145	.55247	.03733
	yes	57	4.4357	.58397	.07735
Attitude towards Personal Therapy	no	218	76.26	7.255	.491
	yes	57	80.77	7.937	1.051
Selfsufficiency	no	223	2.6558	.63102	.04226
	yes	57	2.6491	.67787	.08979
PPD	no	222	5.6188	.73266	.04917
	yes	57	6.1338	.61594	.08158
Acceptance	no	220	54.15	7.836	.528
	yes	57	46.88	10.163	1.346
Self-Compassion	no	209	3.2806	.66357	.04590
	yes	55	2.9070	.71030	.09578
Selfkindness	no	220	3.2491	.76603	.05165
	yes	56	2.8964	.76371	.10206
Selfjudgement	no	222	3.1432	.93703	.06289
	yes	57	2.5649	.94425	.12507

Table D8: Descriptive statistics on abuse scores considering pre-therapy training.

	Pre-training therapy?	*N*	*Mean*	*Median*	*Standard Deviation*	*Minimum score*	*Maximum score*	*Skew*
Physical	Yes	105	5.99	5	2.05	5	15	2.74
Abuse	No	272	5.76	5	2.15	5	21	4.24
Emotional	Yes	107	10.25	9	4.87	5	25	0.98
abuse	No	270	8.13	7	3.96	5	25	2.01
Sexual	Yes	108	5.86	5	3.09	5	23	4.16
Abuse	No	272	5.55	5	2.56	5	25	5.50
Emotional	Yes	107	11.85	11	4.87	5	25	0.51
Neglect	No	270	8.76	8	3.93	5	24	3.94
Physical	Yes	107	7.26	6	2.68	5	18	1.51
Neglect	No	274	5.93	5	1.61	5	13	1.89

Table D9: Trainees use of therapy pre-training by experience of physical abuse

		I was bruised by someone in my family					
		Never	Rarely	sometimes true	often true	very often true	Total
Therapy pre-training	Yes	84	12	6	3	2	107
		26%	41%	33%	33%	50%	28%
	No	236	17	12	6	2	273
		74%	59%	67%	67%	50%	72%
Total		320	29	18	9	4	380
		100%	100%	100%	100%	100%	100%

Table D10: Descriptive statistics: scores by pre-training therapy

therapy pre-training		Attitude towards Personal Therapy	self-sufficiency	PPD	Self-Stigma	Acceptance	Self-Compassion	non-avoidant coping	avoidant coping
yes	N	112	114	114	111	112	106	120	116
	Mean	79.26	2.5154	6.0175	25.73	48.22	2.9975	5.3958	4.6049
	Std. Deviation	8.118	.67696	.66890	3.641	9.554	.70853	1.02058	.54796
	Median	78.00	2.5000	6.0000	25.00	49.50	2.9615	5.5000	4.5000
	Minimum	59	1.00	4.13	18	22	1.08	3.00	3.33
	Maximum	102	4.75	7.00	39	69	4.85	8.00	5.83
	Skewness	.343	.288	-.572	.773	-.548	.034	.269	.233
no	N	277	285	282	277	294	272	296	294
	Mean	77.06	2.7202	5.6281	26.16	53.52	3.2551	5.6368	4.4773
	Std. Deviation	7.761	.66110	.73020	3.490	8.048	.64857	1.00542	.57179
	Median	77.00	2.7500	5.6250	26.00	54.00	3.2692	5.5000	4.5000
	Minimum	54	1.00	3.63	19	20	1.85	2.00	2.83
	Maximum	101	4.50	7.00	35	70	5.00	8.00	6.17
	Skewness	-.237	.122	-.304	.453	-.442	.194	-.135	-.141
Total	N	389	399	396	388	406	378	416	410
	Mean	77.69	2.6617	5.7402	26.04	52.06	3.1828	5.5673	4.5134
	Std. Deviation	7.918	.67124	.73381	3.534	8.803	.67499	1.01449	.56740
	Median	78.00	2.7500	5.7500	26.00	53.00	3.1538	5.5000	4.5000
	Minimum	54	1.00	3.63	18	20	1.08	2.00	2.83
	Maximum	102	4.75	7.00	39	70	5.00	8.00	6.17
	Skewness	-.038	.155	-.376	.541	-.574	.089	-.021	-.056

The Boxplots below were examined during exploration of variables in preparation for a discriminant analysis.

Intrapersonal Variables:

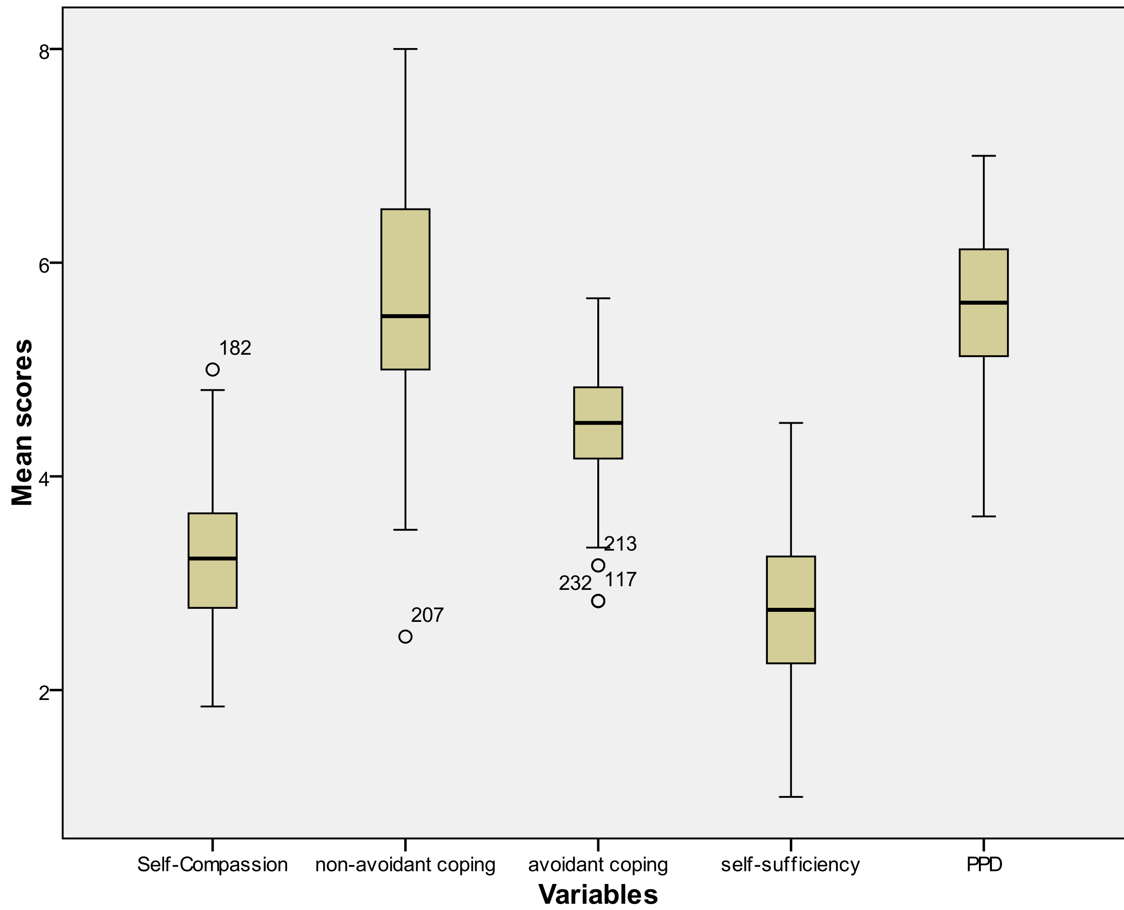

Figure D1: Distribution of Intrapersonal Variables using Mean scores

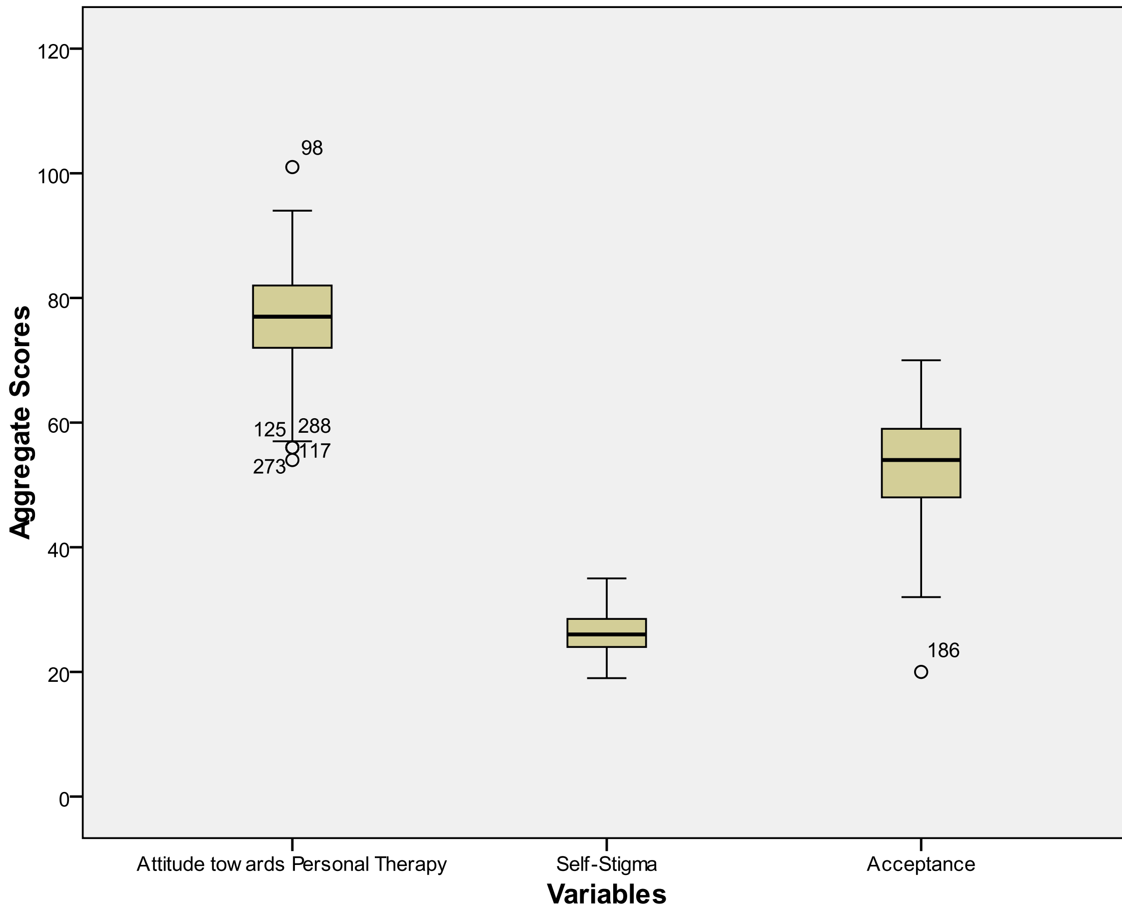

Figure D2: Distribution of Intrapersonal Variables using aggregate scores

Table D11: Descriptive statistics: intrapersonal variables and current use of personal therapy

Current use of Personal Therapy		Attitude towards Personal Therapy	self-sufficiency	PPD	Self-Stigma	Acceptance	Self-Compassion	non-avoidant coping	avoidant coping
not considering personal therapy	N	97	101	101	99	106	96	105	103
	Mean	73.34	2.7847	5.1262	27.03	56.55	3.4319	5.7095	4.3608
	Std. Deviation	8.022	.66147	.65705	3.663	6.975	.71463	1.07368	.58582
	Median	73.00	2.7500	5.1250	27.00	56.50	3.4615	5.5000	4.3333
	Minimum	54	1.25	3.63	20	42	1.85	2.00	2.83
	Maximum	91	4.50	6.75	35	70	5.00	8.00	5.67
	Skewness	-.120	.237	.034	.472	-.002	.001	-.288	-.121
actively considering personal therapy	N	101	104	102	103	106	100	108	108
	Mean	78.06	2.7620	5.7279	25.87	53.81	3.2173	5.6991	4.5432
	Std. Deviation	7.487	.67315	.60893	3.307	7.198	.62052	1.00916	.57164
	Median	79.00	2.7500	5.7500	26.00	54.50	3.2692	5.5000	4.5000
	Minimum	60	1.00	3.63	19	33	1.92	3.50	3.17
	Maximum	101	4.50	7.00	34	70	4.65	7.50	6.17
	Skewness	.025	-.076	-.352	.163	-.417	.074	.030	.251
used/using personal therapy	N	79	80	79	75	82	76	83	83
	Mean	80.35	2.5844	6.1408	25.40	49.23	3.0815	5.4639	4.5361
	Std. Deviation	5.709	.63264	.53085	3.296	8.565	.54065	.89641	.53726
	Median	80.00	2.5000	6.1250	25.00	49.00	3.0385	5.5000	4.5000
	Minimum	66	1.25	4.63	21	20	1.85	2.50	2.83
	Maximum	94	4.25	7.00	35	67	4.19	7.50	5.67
	Skewness	.250	.219	-.362	.687	-.446	.206	-.331	-.720
Total	N	277	285	282	277	294	272	296	294
	Mean	77.06	2.7202	5.6281	26.16	53.52	3.2551	5.6368	4.4773

Std. Deviation	7.761	.66110	.73020	3.490	8.048	.64857	1.00542	.57179
Median	77.00	2.7500	5.6250	26.00	54.00	3.2692	5.5000	4.5000
Minimum	54	1.00	3.63	19	20	1.85	2.00	2.83
Maximum	101	4.50	7.00	35	70	5.00	8.00	6.17
Skewness	-.237	.122	-.304	.453	-.442	.194	-.135	-.141

Table D12: Correlations Intrapersonal variables

	Attitude towards Personal Therapy	*PPD*	*Self-Stigma*	*Acceptance*	*Self-Compassion*
PPD	.705**				
Self-Stigma	.312**	-.134*			
Acceptance	-.365**	-.283**	-.179**		
Self-Compassion	-.273**	-.229**	-.201**	.603**	
Avoidant Coping	.235**	-.246**	.086	-.411**	-.34**

** significant at p=0.001, * significant at p=0.005

Interpersonal Variables

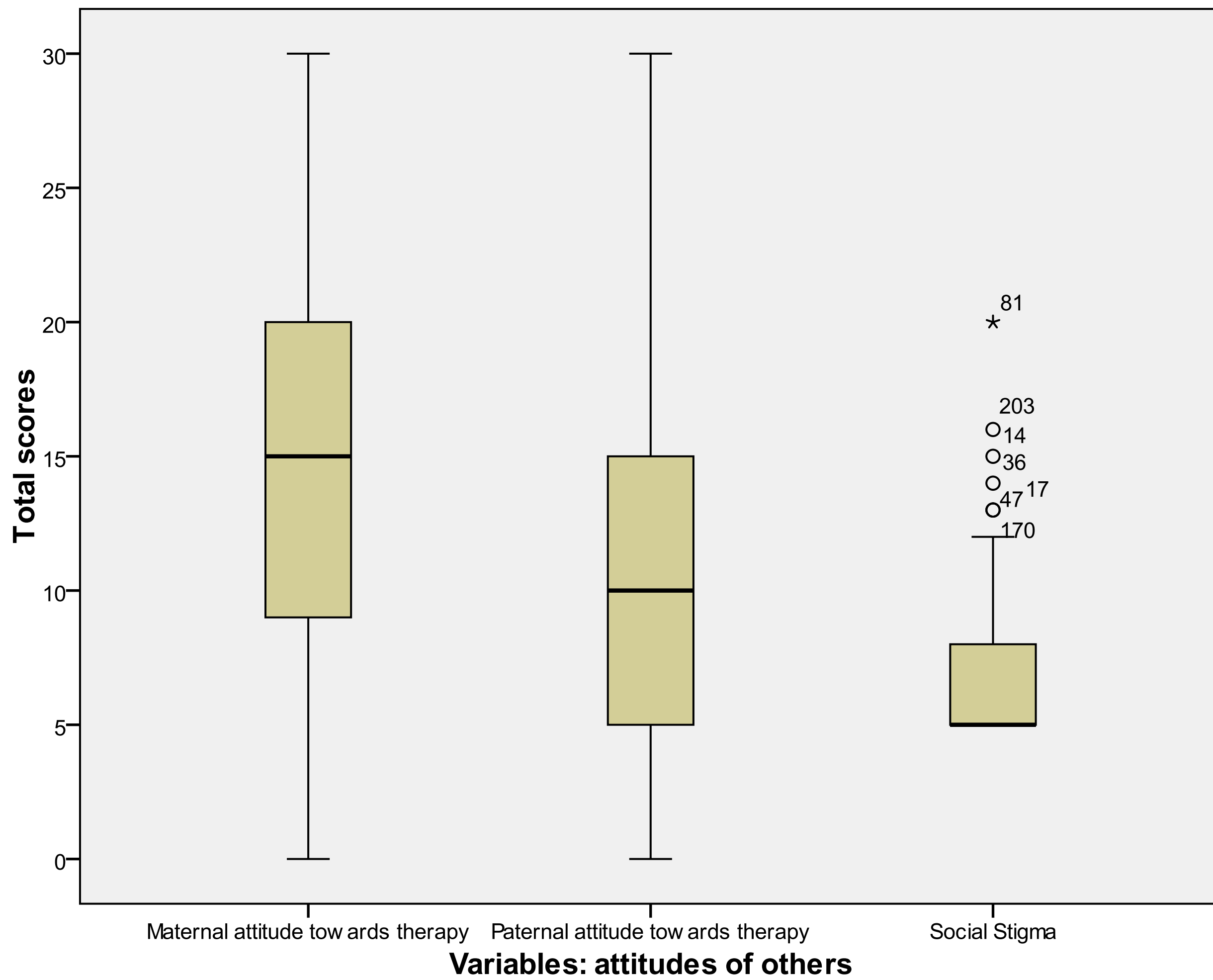

Figure D3: Distribution of interpersonal variables concerning attitudes of others.

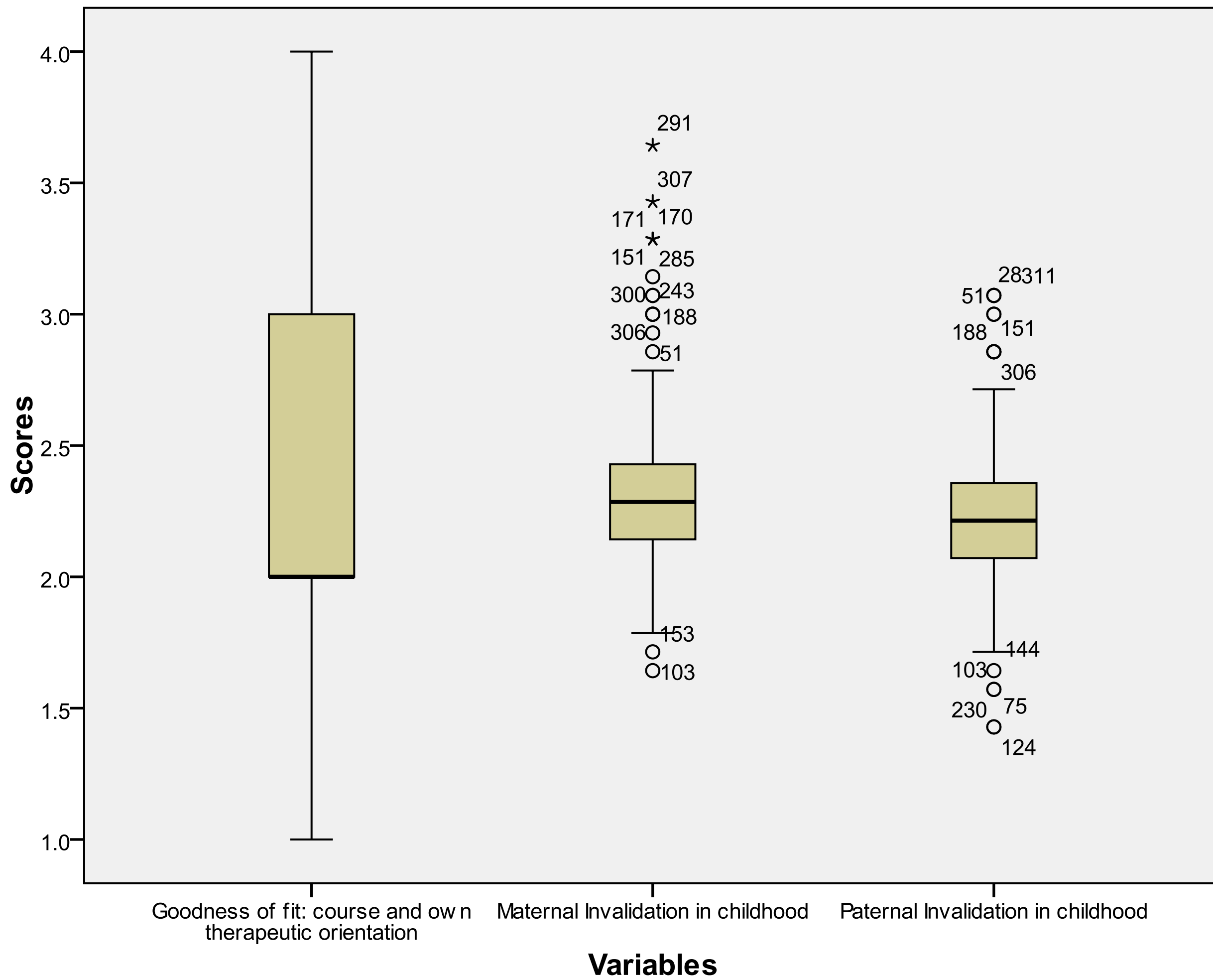

Figure D4: Distribution of Interpersonal variables: invalidation and goodness of fit.

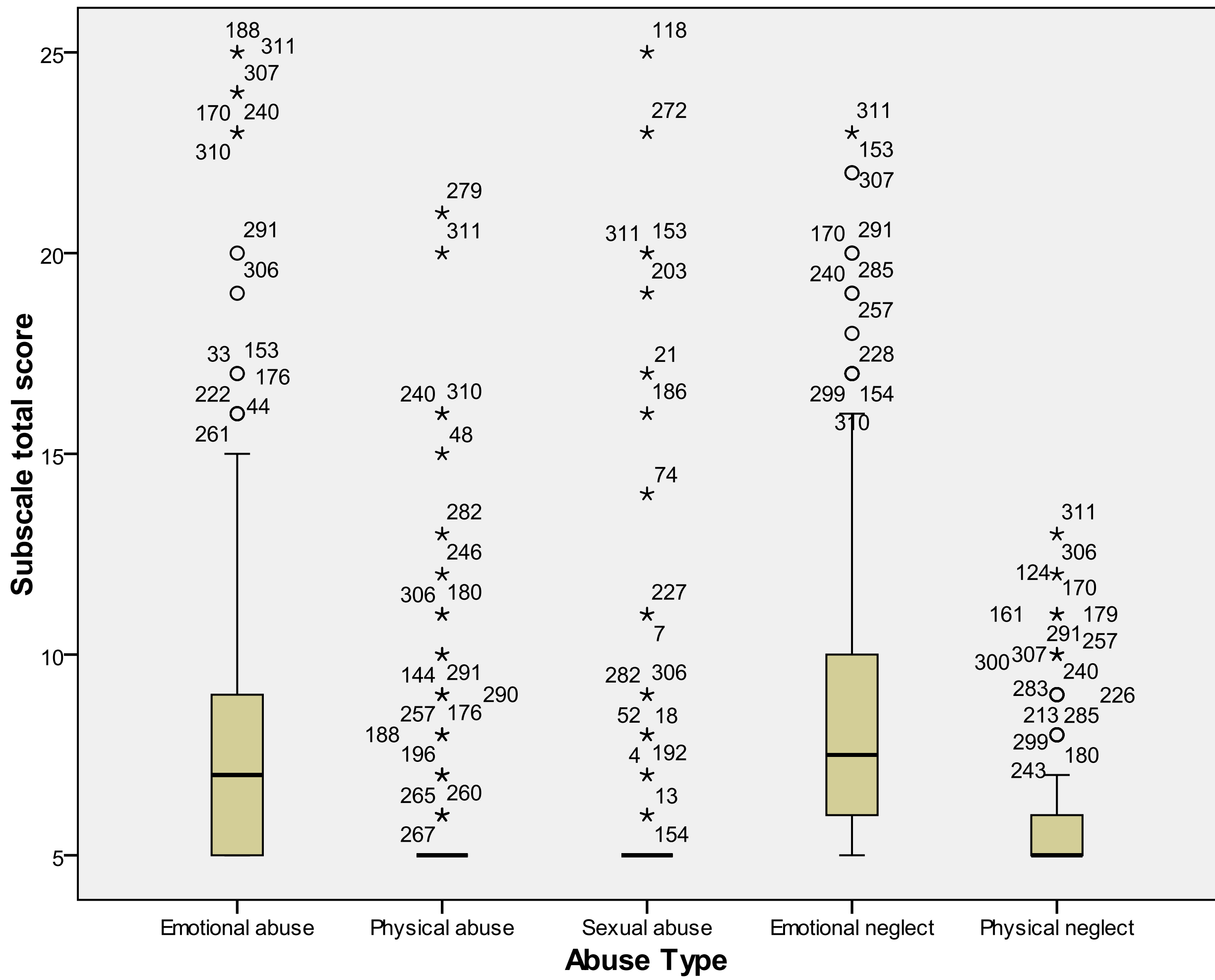

Figure D5: Distribution of Abuse scores.

Table D13: Descriptive statistics: interpersonal variables

Current use of Personal Therapy			Fit	Maternal attitude towards therapy	Paternal attitude towards therapy	Social Stigma	Maternal Invalidation in childhood	Paternal Invalidation in childhood
not considering personal therapy	N		111	91	91	99	95	90
	Mean		1.95	15.30	10.58	6.57	2.2534	2.1873
	Std. Deviation		.666	6.244	6.259	2.479	.20490	.22526
	Median		2.00	16.00	10.00	5.00	2.2143	2.1429
	Minimum	very good		1	0	5	1.79	1.43
	Maximum	ok		27	25	20	3.14	2.86
	Skewness		.050	-.223	.126	2.461	1.581	.018
actively considering personal therapy	N		116	100	94	102	97	93
	Mean		2.06	15.55	11.19	6.50	2.3395	2.2089
	Std. Deviation		.749	7.097	7.492	2.598	.29846	.25083
	Median		2.00	16.00	11.00	5.00	2.2857	2.2143
	Minimum	very good		0	0	5	1.64	1.43
	Maximum	poor		30	30	18	3.71	2.71
	Skewness		.027	-.167	.276	2.264	1.447	-.159
used/using personal therapy	N		84	75	76	78	74	70
	Mean		2.15	12.64	9.07	6.72	2.3745	2.2745
	Std. Deviation		.736	7.443	6.272	2.012	.34607	.35696
	Median		2.00	12.00	8.00	6.00	2.3214	2.2143
	Minimum	very good		0	0	5	1.71	1.57
	Maximum	poor		30	24	12	3.64	3.07
	Skewness		-.068	.354	.341	.968	1.523	.593
Total	N		311	266	261	279	266	253
	Mean		2.05	14.64	10.36	6.58	2.3185	2.2194
	Std. Deviation		.719	7.009	6.764	2.397	.28760	.27754

Median		2.00	15.00	10.00	5.00	2.2857	2.2143
Minimum	very good		0	0	5	1.64	1.43
Maximum	poor		30	30	20	3.71	3.07
Skewness		.033	-.052	.291	2.114	1.691	.458

Table D14: Descriptive statistics: abuse

Current use of Personal Therapy		Emotional abuse	Physical abuse	Sexual abuse	Emotional neglect	Physical neglect
not considering personal therapy	N	94	95	96	96	96
	Mean	7.02	5.28	5.48	7.60	5.49
	Std. Deviation	2.441	.871	2.393	2.630	1.114
	Median	6.00	5.00	5.00	7.00	5.00
	Minimum	5	5	5	5	5
	Maximum	16	10	23	17	10
	Skewness	1.807	3.551	5.916	1.187	2.706
actively considering personal therapy	N	99	100	97	98	100
	Mean	8.29	5.80	5.39	8.66	5.87
	Std. Deviation	4.217	2.010	2.168	4.181	1.606
	Median	7.00	5.00	5.00	7.00	5.00
	Minimum	5	5	5	5	5
	Maximum	24	16	20	24	11
	Skewness	1.788	3.669	6.083	1.661	1.963
used/using personal therapy	N	77	77	79	76	78
	Mean	9.26	6.31	5.82	10.34	6.54
	Std. Deviation	4.728	3.113	3.145	4.441	1.952
	Median	8.00	5.00	5.00	10.00	6.00
	Minimum	5	5	5	5	5
	Maximum	25	21	25	23	13
	Skewness	1.695	3.181	4.706	.657	1.226
Total	N	270	272	272	270	274
	Mean	8.13	5.76	5.55	8.76	5.93
	Std. Deviation	3.957	2.150	2.560	3.928	1.618
	Median	7.00	5.00	5.00	8.00	5.00

Minimum	5	5	5	5	5
Maximum	25	21	25	24	13
Skewness	2.014	4.248	5.500	1.369	1.891

Table D15: Correlations Interpersonal variables

	Maternal attitude to therapy	*Maternal Invalidation in Childhood*	*Emotional abuse*
Maternal Invalidation in Childhood	-.274**		
Emotional Abuse	-.311**	.558**	
Emotional Neglect	-.350**	.363**	.684**

** significant at p=0.001, * significant at p=0.005