

Clinical Psychologists' Personal Experiences of Psychological Distress

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## **ABSTRACT**

Clinical psychologists do not appear to be willing to talk about their own experiences of distress. This may be due to the scientist practitioner model that has dominated the profession for some time. Recently, there appears to be a shift towards a reflective practitioner model with a growing interest in personal and professional development which may provide a cultural shift. It is clear from the literature that psychologists' own experiences of distress prior to training, influence their decision to pursue therapeutic careers. In addition to this, there is evidence that suggests that the life experiences of psychologists influences the theoretical orientations that they use in practice. The present study aims to address the gaps in the literature by exploring the influence of distressing experiences that occur before training and how these experiences influence the decision to train as a clinical psychologist. Furthermore, the present study aims to explore how experiences of distress influence the development of a clinical psychologist's preferred theoretical orientation.

Eight participants' accounts were analysed by using Interpretative Phenomenological Analysis. The following four themes were identified; how experiences of distress influence the career pathway to clinical psychology, being a professional who has experiential knowledge of distress, how personal experiences of distress influence how clinical psychologists relate to clients and how distress influences the way change processes are understood. Participants acknowledged the influence of experiential distress on career choice and on theoretical orientation, however this was one of many influences that were considered to be important. The findings have both clinical and research implications which are discussed.

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# **1 INTRODUCTION**

This chapter details the literature relevant to this study. A literature search was conducted using PsycINFO, PsycArticles and CINAHL Plus. No parameters were set for search time period. Terms and permutations used include mental disorder, wounded healer, life experiences, mental health professionals, occupational choice, personal development and theoretical orientation. References of relevant articles were scrutinised to identify articles that had been missed during the search. New articles were discovered by using the databases to check for the number of times that key articles were cited in other articles.

Clinical psychologists are the group about whom the study is concerned. Examples of the roles undertaken by clinical psychologists include those of consultant, educator, employer, expert witness, evaluator, lecturer, manager, practitioner, researcher, supervisor or therapist. However, as there is a lack of research that explores the viewpoints of clinical psychologists and their personal experiences of distress, the following review will draw on research on clinical psychologists as well as literature exploring the perspectives of affiliated professionals such as counselling psychologists, psychotherapists and family therapists.

In this introduction, current psychological models of distress will be outlined. This will be followed by a review of the literature pertaining to experiential knowledge of distress amongst clinicians. Following this, the literature concerning experience of psychological distress and the development of a theoretical orientation will be examined. Finally, the aims of this study will be presented.

## **1.1 Psychological Distress**

In this section a definition of psychological distress will be considered. Following this, outlines of psychological and psychiatric model of distress are provided.



Psychological distress is a term that is used widely in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and to a lesser extent in the International Classification of Diseases (ICD) system (Phillips, 2009). The term appears to be a nebulous one. Even though references are made to it when differentiating between diagnoses in both classification systems, a definition of psychological distress does not exist in either one. Both diagnostic systems use psychological distress as a stand-alone symptom, as a qualifier of other symptoms and as a general measure of severity (Phillips, 2009). Due to this, there can be a wide range of interpretations of the corresponding diagnostic criteria. This is congruent with the perspective held by the American Psychological Association which suggests that “A universal definition of psychological distress and impairment has not yet been created”, (APA, 2006, p. 6). This has often resulted in differing definitions in the literature. For example, Munsey, (2006) describes distress as “an experience of intense stress that is not readily resolved, affecting well-being and functioning, or disruption of thinking, mood and other health problems that intrude on professional functioning”.

#### 1.1.1 Psychological Models of Distress

In order to illustrate how distress has been conceptualised and interpreted within the literature, a brief overview of the main psychological models and their approach to conceptualising distress is examined below.

Different modalities taking their own position on the development and maintenance of distress. For instance, the cognitive behavioural tradition suggests that distress occurs when the individual is locked into unhelpful patterns of interpretation and behaviours (Dudley & Kuyken, 2006). From this, comes the idea that evaluating and modifying dysfunctional thinking can affect emotional wellbeing.

In contrast to this, psychodynamic approaches suggest that distress occurs due to unconscious attempts to avoid emotional pain (Leiper, 2006). The term

psychodynamic refers to an umbrella term that encompasses many approaches that have psychoanalytic roots. The approach suggests that the individual unconsciously draws upon defences in order to avoid distress. Furthermore, the psychodynamic approach goes on to suggest that failing defences are what give form to and maintain distress (Leiper, 2006)

Systemic approaches see distress as occurring due to problems in interaction and communication between people (Dallos & Stedmon, 2006). This approach has progressed from emphasising patterns of behaviour to now focusing on the importance of language and the joint construction of understanding between those in a system (Dallos & Stedmon, 2006). In this approach, distress is seen as arising from the failing solutions that are applied to difficulties.

Psychiatric discourses position psychological distress as a result of genetic and developmental vulnerabilities, exposed by stress in life. An example of this conceptualisation is encapsulated in the diathesis–stress model (Ingram & Luxton, 2005). The term ‘diathesis’ is synonymous with vulnerability. The vulnerability is considered inherent within the individual and is thought of as being stable, but not unchangeable, over the lifespan. The medical model exerts a strong influence and is the dominant way that distress is thought about and treated in the west (Rapley, Moncrieff & Dillon, 2011).

As the definitions of distress differ in the literature, for the sake of clarity, throughout this study, the term *distress* will be used to refer to the experiences that are sometimes called mental health problems, mental illness or psychopathology (Cromby, Harper & Reavey, 2013). The term distress includes overwhelming emotional states that disrupt everyday functioning, hearing and seeing things that other people do not hear or see and holding beliefs that are considered unusual to others (Cromby et al., 2013). This understanding of distress aims to situate it as part and parcel of everyday life and not as a cluster of symptoms that can be understood separately from everyday experience (British Psychological Society, 2014). This definition also allows engagement with the meaning of distress in a person’s life because it alludes to distress being

influenced by social and material conditions, life events, relationships, psychology and biology.

## **1.2 Establishing Prevalence Rates of Distress amongst Psychologists**

As noted above, psychological distress has been defined and operationalised in a variety of ways when considering the aetiology and maintenance of problems. At the same time, efforts have been made to establish prevalence rates of distress amongst psychologists. This section will consider the literature regarding this and will go on to outline research that considers psychologists' personal experiences of distress.

Historically, prevalence rates of distress amongst psychologists have been primarily anecdotal in nature (Thoreson, Miller, & Krauskopf, 1989). In response to this, attempts have been made to establish the prevalence rate of clinical psychologists who have experienced distress at such a level that it has affected their daily functioning. This has been difficult due to the lack of consensus in defining distress (Smith & Moss, 2009). The majority of the data has been gathered through quantitative methods and self-report questionnaires that are randomly delivered by post and returned on a voluntary basis (Katsavdakís, Gabbard, & Athey, 2004). The data is usually obtained through the use of a national database, such as a specialty division within the American Psychological Association (Katsavdakís et al., 2004).

For instance, Deutsch (1985) conducted a survey of 264 mental health professionals' (psychologists, ward staff) problems and produced findings that suggested that 57% of her sample had experienced depression. Following this, Thoreson, Miller and Krauskopf (1989) surveyed a sample of 379 licensed psychologists in order to ascertain levels of distress. Their findings suggested that 10% of their sample had experienced psychological distress during the previous year. In addition, Gilroy, Carroll, and Murra, (2002) surveyed 425 counselling psychologists and found that 62% of their sample identified themselves as depressed whilst 42% identified themselves as experiencing

suicidal ideation or suicidal behaviour. It is possible that these studies are affected by a sampling bias where psychologists who are experiencing distress are more likely to respond to surveys about prevalence of distress, this is indicated by the low response rates to the surveys that were posted to participants. Furthermore, within these studies, the categories for psychological distress were broad, for instance they included categories such as marriage, divorce, relationship difficulties, poor self-esteem or self-confidence, anxiety, and problems related to career (Pope & Tabachnick, 1994).

The prevalence rates of psychological distress appear to be quite high in the psychology population, this becomes more striking when compared to the incidence rates of mental health problems in the general public. For instance, the adult psychiatric morbidity survey (APMS) which provides data on the prevalence of both treated and untreated mental health problems in the English adult population suggests that the prevalence rates of mental health problems for adults (aged 16-64) is 17.6%. (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009). As these figures are based on a British sample it is hard to make a direct comparison with the prevalence data above which consists of studies based on an American population, however it does give an indication of the difference between a sample of psychologists and the general population.

In conclusion, the limited evidence examining reported experiences of psychologists in distress has been of a quantitative nature with the majority of it based on American therapists working during the late 1980's and early 1990's (Charlemagne-Odle, Harmon, & Maltby, 2014). The research does not consider experiences of distress that have occurred prior to becoming a clinical psychologist nor does it consider whether these experiences have influenced the decision to become a psychologist. In response to this, this study aims to qualitatively explore the personal accounts of a period of time experienced as distressing for trainee and qualified clinical psychologists in Britain prior to clinical training. It is important to capture these accounts because it allows more diverse

representations of clinical psychologists who have experienced distress. The researcher's hope is that diverse representations of clinical psychologists with personal knowledge of psychological distress will culminate in these experiences being normalised as opposed to pathologised.

#### 1.2.1 Clinical Psychology and Personal Experiences of Psychological Distress

The literature that explores personal experiences of distress states that psychologists report a higher incidence of personal problems during childhood and in their family of origin when compared to the general public. For instance, Murphy and Halgin, (1995) surveyed 56 clinical psychologists and 53 social psychologists about the influences on their career choice. They found that clinical psychologists were more likely than social psychologists to have been influenced in their career selections by experiences of psychological distress in themselves, in their families of origin and also by desires to resolve personal problems.

This is supported by Elliott and Guy, (1993) who conducted a survey of the prevalence of childhood trauma, family dysfunction, and current psychological distress among 340 mental health professionals (clinical psychologists, psychotherapists, psychiatrists and clinical social workers) and 2,623 professionals in other occupations (chemists, engineers, financial analysts, fine artists, microbiologists, musicians, statisticians). They found that mental health professionals reported higher rates of physical abuse, sexual molestation, parental alcoholism, psychiatric hospitalization of a parent, and greater family dysfunction in their families of origin than did other professionals.

In addition, Nikcevic, Kramolisova-Advani, and Spada,(2007) conducted a survey of 166 graduates (75 psychology graduates and 91 business graduates). Their findings suggested that psychology students who wanted to work in the clinical domain reported higher rates of perceived childhood sexual abuse and neglect when compared with, both psychology students with no clinical aspirations and business students. The literature suggests that undergraduate and post graduate psychologists are more likely to have experienced psychological distress

compared to the general public. However it may be that they are more open about experiencing psychological distress than the general public, perhaps due to the influence of their educational and career choices. The above studies used random sampling methods to recruit a representative set of participants, however the low response rates to the surveys indicates that the data may be affected by a non-response bias. It should also be noted that participants who did respond were required to recall events from the past, these memories may be fraught with selective distortion and bias which brings into question the validity of these studies. As a result, the conclusions drawn from these studies are tentative.

### **1.3 Distressing Experiences as Motivation to Train as a Clinical Psychologist**

As stated above, psychologists report higher occurrences of mental health problems in their early life and in their family of origin when compared to the general public. In this section, the literature regarding the motivations to train as a clinical psychologist are considered.

According to psychoanalytic theory people choose a particular career due to the influence of significant childhood experiences, family dynamics, and familial vocational choices (Obholzer, Roberts, & Workshop, 1994). This is worth some consideration as the research base suggests that experiences of distress influence the decision to train as a psychologist. For instance, clinical psychologists state that they have been influenced in their career selections by experiences of psychological distress in themselves and in their families of origin (Murphy & Halgin, 1995). From this it can be inferred that distressing experiences do influence the decision to train as a psychologist. When this has been explored further, it has been suggested that for some individuals the motivation for training as a psychologist is to understand their own experiences of distress and to discover what will keep them on the recovery path (Harper, 2003).

Following this, Farber, Manevich, Metzger and Saypol, (2005) identified often noted themes in the literature on the motivations for psychotherapists' career

paths. They interviewed three psychotherapists to establish a narrative and themes for the career choice of psychotherapists. Their results suggested that themes such as cultural marginalization, a need for safe intimacy and a need for self-growth influence the decision to train as a therapist. Unfortunately, two of the participants were junior authors who were directly linked to the study. Due to this vested interest in the study and because of the small sample size and, the interpretation of their findings is compromised, nevertheless some conclusions may still be drawn cautiously from the study.

In contrast to this, Huynh and Rhodes, (2011) interviewed 15 undergraduate psychologists in order to create a narrative account of why they were interested in becoming clinical psychologists. They conducted a thematic analysis of the interview data and their results suggested that the desire to emulate professionals who have helped or be better than ones who did not offer support is a motivating factor to train as a psychologist. They claimed that for their sample, this occurred because the majority of participants had experienced psychological distress in childhood, adolescence or early adulthood, which had then inspired them through both good and bad encounters with helping professionals. This career choice is then consolidated by specific career advice or by observing helping role models (Huynh & Rhodes, 2011). The study appears to be of a good quality, it is coherent, grounded in examples, situates the data and the researchers are clear about the procedure and about the specific research tasks. These are all hallmarks of quality in qualitative research (Elliot, Rennie and Fischer, 1999).

Despite these findings little is known about the processes that lead people who have experienced psychological difficulties before clinical training to pursue the field of clinical psychology. A more substantial and richer understanding of the lives of psychologists who have experienced distress is required if these experiences are to inform the education and training of clinical psychologists. This may result in increasing the visibility of psychologists with experiential knowledge of distress which may then encourage a shift toward normalising these experiences.

## **1.4 The Wounded Healer**

The idea that distressing experiences influence the decision to become a clinical psychologist is best illustrated in the concept of the “wounded healer”. The nature, development and operation of this archetype is outlined below.

The concept has its origins in Greek mythology and shamanistic traditions (Kirmayer, 2003). Notions of this construct can be found in religion, philosophy, and art, but they also have a place in psychotherapy, counselling, and medicine (Jackson, 2001). C.G. Jung was probably the first psychotherapist to speak openly of the archetype drawing from Greek mythology and exploring its applications to psychology (Smith, 1996).

The wounded healer paradigm suggests that wounded and healer can be represented as a duality rather than a dichotomy. In this way “woundedness” lies on a continuum, not on the degree of woundedness but on the ability to draw on woundedness in the service of healing others (Jackson, 2001). The archetype suggests that through the experience of personal suffering and internal conflict the future therapist becomes psychologically aware and able to understand and help others (Jung, 1951). In this way, the healing power emerges from the healer’s own wounds (Zerubavel & Wright, 2012). Thus, the more healers can understand their own “wounds” and journey of recovery, the better position they are in to guide others through such a process, while recognizing that each person’s journey is unique (Gelso & Hayes, 2007).

It is important to differentiate between the wounded healer and the impaired professional. The latter refers to therapists who are wounded and whose personal distress adversely impacts their clinical work (Jackson, 2001). Thus, it is critical that a therapist’s wounds are mostly healed, or at least understood and



processed sufficiently, to prevent them from interfering with therapy and the therapeutic relationship (Gelso & Hayes, 2007).

Due to codes of practice, psychologists have an ethical responsibility to notice, address, and monitor impairment in colleagues. This is thought to complicate the issue of engaging in open dialogue about how a colleague's or supervisee's wounds positively influence or interfere with their work (Cain, 2000). It has been suggested that the dilemma wounded healers often face, concerns the potential stigma they might encounter if the nature of their wound is disclosed, leading to judgment by colleagues regarding their competence to practice (Zerubavel & Wright, 2012). These concerns can result in secrecy, self-stigma, and shame. Thus, there has been a relative silence around the topic of wounded healers in Psychology.

It may be that this lack of dialogue encourages secrecy and shame among those with such experiences, thereby preventing access to support, guidance and intervention if needed (Zerubavel & Wright, 2012). In contrast to this, in some areas of mental health treatment, the wounded healer is recognized for playing a distinctive role as a provider. For instance, in alcohol and substance misuse services, it is more common for practitioners to have struggled with and overcome addiction as this "lived experience" is thought to be useful when working with clients (Jackson, 2001).

The absence of dialogue raises concerns about the personal and professional development of psychologists with experience of a wounding. It could be argued that the absence of a dialogue inhibits the profession from cultivating an environment of safety so that wounded healer feels able to bring concerns to supervisors and consultants (Gelso & Hayes, 2007). In this way, personal development and growth can be facilitated by the profession. Calhoun and Tedeschi, (2008) have captured this possibility in their exploration of the posttraumatic growth that can occur as a result of coping effectively with traumatic experiences. They describe five domains in which growth is often reported following successful engagement with traumatic experiences: (1)

viewing the self as simultaneously vulnerable and strong; (2) discovering new potential; (3) reporting an enhanced appreciation for life; (4) developing a deeper sense of purpose and meaning; and (5) having deeper interpersonal connections and greater empathy. Growth in these domains can foster in wounded healers, a deeper insight regarding the nature of the client's struggles and lead to optimism regarding client outcomes (Zerubavel & Wright, 2012).

One critique of the wounded healer archetype is that distressing experiences may not be the only reason why people are attracted to being a clinical psychologist. For instance, Huynh and Rhodes, (2011) found that a significant number of trainee psychologists did not identify distressing experiences as being related to their career choice. In contrast, these students were motivated by the positive, satisfying experiences they had in helping roles, for some of them these experiences demonstrated their personal suitability for the profession (Huynh & Rhodes, 2011). This mediates against a dominant story of all psychologists as wounded healers (Burns, 2009). Perhaps the view that psychologists are the bearers of psychic wounds is exaggerated and like other professionals their vocational calling is influenced by factors in convergence with or entirely separate from personal experiences of psychological distress (Murphy & Halgin, 1995).

Another critique of the archetype is that studies tend to consider it from a psychodynamic perspective, this may be due to its Jungian origins. Furthermore, there do not appear to be studies that look at the influence that a wounding has on the decision to become a psychologist without using a particular theoretical model as a reference point.

## **1.5 The Culture of Clinical Psychology**

This section considers how the concept of the wounded healer interacts with the perceived culture of clinical psychology. The concept of stigma and the way that this influences how personal experiences of distress are considered amongst psychologists is outlined below.

The literature indicates that experiences of psychological distress are common amongst clinical psychologists. Due to this, it is surprising that these experiences do not appear to be discussed openly during training or in clinical practice. This may be because the profession is still struggling with its identity and how it is compared to or understood alongside other professions (Turpin & Llewelyn, 2009). It may also be due to the assumption that in order to practice clinically, clinical psychologists must remain untouched by difficult life experiences (Davidson & Patel, 2009). This viewpoint is supported by Skorina (1982), who argues that psychology has developed an aura of invulnerability that creates high expectations for self-efficacy and equates personal difficulties with incompetence. From this it is possible to infer that clinical psychologists are positioned as either competent and free of psychological distress or struggling with difficulties and incompetent as a result of this.

This is supported by reflections on the culture of clinical psychology which is thought to be a culture where you “don’t have lunch and work nine hours nonstop” (Charlemagne-Odle et al., 2014, p.243 ). This serves to disable psychologists from admitting distress due to the pressure to be seen as coping and competent. In addition to this, clinicians have expressed fear and dissatisfaction with negative comments made about psychologists in distress (Barnett, Baker, Elman, & Schoener, 2007). The result of this is that personal experiences of psychological distress may be kept hidden and seen as taboo within the profession (Charlemagne-Odle et al., 2014).

#### 1.5.1 Stigma and Experiential Knowledge of Psychological distress

Social stigma is the disapproval of a person or group on socially characteristic grounds that are perceived, and serve to distinguish them, from other members of a normative group in society (Pilgrim, 2014). Attributes associated with social stigma often vary depending on the geopolitical and corresponding socio-political contexts employed by society, in different parts of the world. According to Goffman, (1963) there are three forms of social stigma: overt or external

deformations such as obesity, deviations in personal traits such as mental illness and tribal stigmas which are traits, imagined or real, of ethnic group, nationality, or of religion that is deemed to be a deviation from the prevailing normative ethnicity, nationality or religion. When individuals are categorised into certain groups, the labelled person is subjected to status loss and discrimination. Discrimination is thought to be the unjust or prejudicial treatment of different categories of people, on the grounds of differences such as 'race', age, mental illness or gender. (Wilder and Simon, 2003).

As stated above, stigma occurs when an individual is identified as deviant, linked with negative stereotypes that engender prejudiced attitudes, which are acted upon in discriminatory behaviour (Pilgrim, 2014). This is relevant to this study because the literature base suggests that people with experience of mental health problems experience a great deal of discrimination in the NHS workplace (Department of Health, 2002).

For instance, Jorm, Korten, Jacomb, Christensen and Henderson, (1999) surveyed 1128 psychiatrists, 454 clinical psychologists and 872 GPs. With an overall response rate of 85%, their results suggested that mental health professionals including clinical psychologists hold stereotyped beliefs and stigmatised attitudes about people with experiences of distress. This is supported by Servais & Saunders, (2007) who conducted a survey of clinical psychologist's perceptions of people with mental illness. They found that their sample of clinical psychologists perceived individuals with mental illness in a negative light. This study had a low response rate of 34% indicating that the data is susceptible to non-response bias. Those who did not respond were not systematically followed up to ascertain whether their answers differed significantly from those who answered the survey and so the findings from this study must be interpreted with caution.

With this in mind, it is important to recognize that psychologists are embedded within a larger social context and are influenced by widely held social beliefs as noted in previous research. (Schulze, 2007). One argument is that psychologists

may not espouse the public's views on mental health issues when approaching their clients' struggles but that they might approach their own and their colleagues' experiences of psychological distress in a manner more consistent with social stigma (Zerubavel & Wright, 2012). It has been proposed that when psychologists move from the stance of the therapist, (e.g., accepting, supporting, validating) to a gatekeeping role (e.g., acting as representatives of the profession, protecting clients, and screening out those who may potentially do harm (Falender, Collins, & Shafranske, 2009), the tendency to be influenced by social stigma may increase.

One explanation of the function of stigma states that it occurs because it allows the belief holder to diminish the threat that mental illness poses to their self-concept and belief in a "just world" (Lerner, 1980). In this way, it allows them to position themselves as different to people who have experienced psychological distress (Servais & Saunders, 2007). As a result of this, they are able to minimise their awareness of their own vulnerability to distress. This process allows individuals to believe that psychological distress only happens to others who somehow deserve it or who bring it on themselves (Lerner & Simmons, 1966). This process may be part of a wider discourse within clinical psychology which claims that it is unacceptable to need personal support as a psychologist. It has been argued that these discouraging messages are learned, by some, during clinical training and observed in psychologist colleagues post qualification (Charlemagne-Odle et al., 2014).

### 1.5.2 Why Does Stigma Matter?

Stigma is a powerful and persistent force, it can lead to social rejection and act as a source of distress in itself (Wright, Gronfein, & Owens, 2000). This is because stigma can lead to increased feelings of shame, guilt, secrecy, diminished self-efficacy, and anger (Wahl, 1999). The negative feelings caused by stigma are pervasive because the beliefs and ideas we hold about ourselves are social: they occur twice, first in interpersonal interactions and then in the mind of the individual (Vygotsky, 1978). These feelings may also be pervasive because in

conjunction with the felt sense of self in space and time, the stories that others tell about you are connected to the stories that you tell about yourself (Hedges, 2010). In this way external stigma may become internalised (Cain, 2000).

This suggests that some psychologists who have experienced distress may battle with negative self-perceptions, reinforced by anticipated and actual social and professional expectations (McCall & Simmons, 1966). These perceptions may start at the beginning of the career pathway, for example, Youngson, (2009) suggests that trainees perceive that if they admit to struggling emotionally, they will in some way be regarded as not coping and not suitable for training.

The perceived norm appears to be that the majority of clinical psychologists have not experienced psychological distress to the point where they would require clinical intervention. If this is the case, then it is important to engage with this discourse as it can lull those in the profession who have not experienced psychological distress (a powerful majority) into “othering”, noting only exceptions to the usual whilst waiting for those in the less powerful minority groups to speak out, rather than facilitating this (Davidson & Patel, 2009). In this way, the stigma of talking about personal experiences of distress continues and this may mean that the diverse experiences of clinical psychologists and the knowledge gained from these experiences is not discussed and shared in the profession.

If this is indeed the case, then it brings to mind the question of what forum clinical psychologists with experience of psychological distress can use to share knowledge and to receive support. It may be that this already occurs in personal circles. With regard to professional forums, the increasing importance of personal and professional development in clinical psychology may provide additional opportunities to be open about and to share experiences. This will be discussed in the following section.

## **1.6 Clinical Psychology and the Influence of Personal and Professional Development**

Within clinical psychology, personal and professional development is defined as a process of developing understanding of the relationship between one's own life history and clinical work (Walsh & Scaife, 1998). The key themes relating to the concept of personal development are thought to be spiritual growth, self-awareness, quality of life, positive thinking and goal setting (Hughes, 2009). This is in line with findings by Mearns, (1997) who suggests that personal development consists of three key features, these are; "a preparedness and willingness to become more aware of one's self, a preparedness and willingness to try to understand one's self and a preparedness and willingness to explore and experiment with one's self i.e. to face fears, examine one's character and risk doing things differently" (p.30). Furthermore, Sheikh, Milne and MacGregor, (2007) have added to the definition of personal development by suggesting that it involves "a process of knowing yourself and understanding how your experience shapes your subsequent encounters with the world" (p.279).

From these definitions it can be inferred that personal development is linked with professional development (Hughes, 2009). Furthermore, the definitions indicate that personal development can be thought of as an interface between personal experiences, professional experiences, self-awareness and personal growth. If this is the case, then this must include experiences of psychological distress as these have been shown to be part of the range of personal experiences of those who practise as psychologists.

The researcher considers that stigma may be a barrier to exploring personal experiences of distress but moves within clinical psychology to embrace epistemologies in addition to the scientist practitioner, have made room for the *person* in the work to take a more central role (Hughes, 2009). This shift has been influenced by the growth of the service user movement which has prompted mental health professionals to take a broader perspective on mental health issues (Youngson, 2009). As a result of this, there appears to be a shift towards a reflective practitioner model which requires clinicians to reflect on the impact of

therapeutic practice on themselves and others both in the moment and retrospectively (Lavender, 2003). These developments appear to invite openness about personal experiences of psychological distress.

#### 1.6.1 Why is Personal Development Important in Clinical Psychology?

In order to be effective, clinical psychologists need to be aware of themselves and their patterns of relating to others (Hughes, 2009). This is relevant to those working within the reflective practitioner paradigm and those working within the frame of the scientist practitioner as the evidence base highlights the importance of therapist –client relationship in therapy outcomes with different models (Horvath, Flückiger, & Symonds, 2011).

Personal development facilitates the process of self-awareness. It has been suggested that personal development gives practitioners resilience in dealing with problems, supports clinicians to take care of themselves, and enables them to contribute to the profession (Youngson et al., 2009). The process of resolving personal experiences of psychological distress may mean that clinical psychologists with these experiences are already engaging in activities that facilitate their personal development. There is great benefit in this, for example clinicians who are confident in exploring aspects of themselves that are uncomfortable or hidden may feel better positioned to engage in this process with service users and carers (Hughes, 2009). From this, it could be argued that the growing interest in personal development has meant that clinical psychologists need to be aware of their own experiences including those of psychological distress and how these influence their professional work.

#### 1.6.2 Psychological Distress, Personal Therapy and Personal Development

Distress experiences are thought to have both positive and negative consequences for psychologists who have experienced them. Nevertheless, such experiences present dilemmas for clinicians to navigate. The literature suggests



that psychologists navigate these dilemmas by taking part in personal therapy (Dearing, Maddux, & Tangney, 2005).

Psychologists deal with the mind but if they are not familiar with their own emotional experiences how can they help someone to understand theirs (Youngson et al., 2009). In order to be useful in clinical work, it has been suggested that therapists must develop “a third eye” to help shift between the client’s position and their own (Hedges, 2010). This reflexivity can be developed through the process of undergoing personal therapy because psychologists are positioned as the client in this encounter (Rake, 2009).

A commitment to personal therapy has been positioned as part of the criteria for qualification in particular professions, for instance it is a requirement for those who want to practice as psychoanalytic psychotherapists (Clark, 1986). In contrast to this, trainee and qualified clinical psychologist are not required to have personal therapy or to demonstrate such a commitment to reflection about their life experiences, this provides a subtle message that clinical psychologists are very different from the clients they work with (Davidson & Patel, 2009). It could be suggested that this is part of the discourse highlighted earlier in this chapter where the stigma of mental health problems in society exerts its influence in clinical psychology in subtle ways. If personal therapy was highlighted as an integral component to clinical training, would this lessen the stigma associated with being in distress and seeking therapy? (Dearing et al., 2005)

The pathologising language of the majority of psychological theory only adds to this stigma (Davidson & Patel, 2009). This is because most theories of therapy are theories of psychopathology (Held, 1991). As a result, those that require therapy are described as the maladjusted, disturbed, regressed, neurotic, psychotic and character disordered (Hubble, Duncan, & Miller, 1999). These ideas may act as a barrier to seeking therapy, they may also be a barrier to exploring personal experiences of distress and subsequent intervention with colleagues and clients.

Personal therapy is thought to lead to an increase in psychological functioning. For instance, Elliot and Guy, (1993) reported that despite experiencing more psychological distress in their families of origin than those outside of the mental health field, mental health professionals reported being less anxious and also reported less depression, dissociation, and sleep disturbance than those in other professions. These findings suggest that those in the mental health field have found successful ways of coping with their problems such as through therapy (Farber et al., 2005). Furthermore, the process of finding solutions to early painful situations, through psychotherapy is thought to be part of the process in which people make a decision to pursue a career as a psychotherapist (Farber et al., 2005). This links to the wounded healer archetype (Smith, 1996) in which individuals are motivated by their personal experiences of pain and recovery to help others who have had similar problems.

It has been suggested that personal therapy is helpful in terms of personal and professional development (Rake, 2009). This is elaborated by Macran and Shapiro (1998) who reviewed studies that investigated how therapists' therapy can influence therapeutic practice. They stated that therapy manages the stressful aspects of clinical work, it ensures good mental health of clinicians, it leads to awareness of personal difficulties, it encourages empathic responsiveness and it allows the therapist as a client to develop a sense of confidence in the therapy process. These themes are linked to the ability of emotional intelligence which is thought to be part of the repertoire of clinicians who are developing personally and professionally in their roles (Goleman, Boyatzis, & McKee, 2003).

### **1.7 Experiential Knowledge of Distress and Theoretical Orientation**

Within this section, the influence of psychological distress on the development of a theoretical orientation is discussed. This is preceded by a definition of theoretical orientation and literature that examines the factors that contribute to the development of a theoretical orientation.

A theoretical orientation is a consistent theory of human behaviour, mental disorder, psychotherapy and the mechanisms of change (Norcross & Prochaska, 1983). Clinicians typically define their practice in terms of the conceptual model that they use to understand clients' problems and to guide interventions (Buckman & Barker, 2010). It has been suggested that arriving at one's theoretical orientation is both a personal and professional endeavour (Bitar, Bean, & Bermúdez, 2007). Bitar et al., (2007) conducted a qualitative study using a grounded theory approach and their findings suggested that factors such as personal philosophy, personality, family of origin and supervision are contributors to the development of a theoretical orientation. These factors are discussed below. The study also fulfilled criteria to be considered of a good quality, for instance it is presented coherently, interpretations are grounded in examples, and the researchers are clear about the procedure and about the specific research tasks.

#### 1.7.1 Personal Philosophy

It has been proposed that practitioners of differing therapeutic orientations can be distinguished by their philosophical beliefs or worldview. (Buckman & Barker, 2010). It is thought that this process of acquisition includes a dynamic interplay between the theory and the personal philosophy of the therapist (Bitar et al., 2007). The process is thought to occur when a theory is found to be congruent with the practitioner's existing personal philosophy. This is consistent with existing literature (Norcross & Prochaska, 1983; Vasco & Dryden, 1994), which suggests that personal philosophy and values are closely linked to acquiring a theoretical orientation. It is thought that a theory becomes an integral part of the structure of the therapists' personal philosophy and values, this is why a particular orientation is selected (Bitar et al., 2007).

#### 1.7.2 Personality

The influence of personality has been identified in the literature as a significant variable in selecting a theory (Arthur, 2001; Scandell, Wlazeiek, & Scandell,

1997; Schwartz, 1978) and, therefore, in the process of theoretical orientation development. This is based on observations that practitioners of differing therapeutic orientations exhibit different personality characteristics (Buckman & Barker, 2010). The process is thought to centre on a goodness-of-fit between a therapist's chosen theory and their personality. For instance, it has been suggested that individuals who have a preference for the unstructured and symbolic as opposed to more concrete and externally observable phenomena tend to be drawn towards psychodynamic and experiential therapies compared to practitioners of a systemic, cognitive behavioural or behavioural orientation (Scandell, et al., 1997).

#### 1.7.3 Family of Origin

It has been suggested that family of origin experiences influence the process of acquiring a theoretical orientation. One proposal is that therapists choose theories that have helped them work through their own family of origin issues. Another idea is that the nature of family of origin experiences sensitised therapists to particular models (Bitar et al., 2007). An example given in the literature is of participants being drawn to models that directly address already resolved family of origin dynamics. In these instances, the models are thought to have provided a new perspective on issues that had previously been painful before being viewed through the lens of this new model (Vasco & Dryden, 1994).

#### 1.7.4 Supervision

The findings in previous studies suggest that supervision is related to preference for theoretical orientation (Guest & Beutler, 1988). This is because supervisors provide important feedback and ask questions that shape the theory development process. This feedback and questioning process is thought to encourage clinicians to conceptualize the therapy process in different ways which leads to integrating the approach into their preferred way of working (Murdock, Banta, Stromseth, Viene, & Brown, 1998). Following this, it has been suggested that

supervisors provide exposure to different theories, through teaching and modelling, this enables therapists to explore different theories and select a model that is a good personal fit (Bitar et al., 2007).

#### **1.7.5 The Influence of Psychological Distress on Developing a Theoretical Orientation**

When asked, clinical psychologists have stated that the convergence of a theoretical tradition's concepts with their own life draws them to that theoretical orientation (Norcross and Prochaska, 1983). It has also been suggested that clinicians become interested in a theoretical orientation because it seems to be consistent with the way they have been helping themselves (Dryden and Vasco, 1991). From this it is possible to infer that experiences of distress may influence a clinician's theoretical orientation.

One critique of the literature is that very few of the studies in this area have been qualitative in nature. Additionally, only a small number of studies have been based on in-depth phenomenological accounts of the process of acquiring a theoretical orientation (Rosin & Knudson, 1986). Furthermore, there has been little research that has explored the influence of distressing experiences on the acquisition of a theoretical orientation.

### **1.8 The Use of Experiential Knowledge**

The literature above suggest a link between early experiences of distress and becoming a psychologist. There also appears to be a link between the theoretical orientation that psychologists utilise and their early experiences of distress. A large literature base exists on professional competence issues such as over identifying with clients due to having experiential knowledge of distress (Kaslow et al., 2007). However, there are virtually no articles that address the potentially beneficial aspects for the professional, their clients and the profession as a whole

(Kottsieper, 2009). This is surprising when it is considered that any experience of moving on from and living with the experience of being in a socially devalued position is clinically useful (Harper, 2003).

With this in mind, the following section examines how psychologists with experiential knowledge of distress use these in their clinical work. The negative and positive aspects of this are considered below.

#### 1.8.1 The Cost of Experiential Knowledge

It has been noted that there are drawbacks to being a clinician who has experienced psychological distress. The literature suggests that one such drawback is having one's own professional competence more closely scrutinised due to talking openly about your own experiences (Kottsieper, 2009). This is associated with stigma which acts as a barrier to talking about these experiences (Cain, 2000). It has been suggested that psychologists are viewed negatively by employers, and colleagues who may question the ability of a psychologist who has struggled with his or her own psychological distress (Barnett et al., 2007).

Other commonly noted negative effects include a decreased ability to be emotionally present and poorly managed countertransference (Cain, 2000). It has also been reported that psychologists describe the tendency to overidentify with their clients. Over identification is an extreme form of identification with clients to a degree that the therapist loses perspective on the therapeutic process (Zerubavel & Wright, 2012). It has been suggested that this may occur due to projection of difficulties and due to having a personal agenda regarding the therapy process (Briere, 1992; Gil, 1988).

Further negative impacts mentioned in the literature include discomfort, anxiety, frustration, and reminders of difficult times when working with clients (Guy, Poelstra, & Stark, 1989). It has also been suggested that therapists with personal experiences of psychological distress experience isolation and vulnerability, they also described feeling tired and upset about difficult situations that arise in clinical

work (Cain, 2000). This may be because they are more vulnerable than other therapists to being traumatized by the clinical work itself (Salston & Figley, 2003). As a result of this, such therapists may find that their ability to remain psychologically present in clinical work is hampered (Cain, 2000).

These drawbacks are important to hold in mind as they may help to identify psychologists whose past experiences hinder their effectiveness in clinical practice and lead to successful intervention to the benefit of the clinician and their wellbeing. However, there is a danger in just focusing on shortcomings, since what we focus on tends to expand (Hedges, 2010). This is because focusing on problems as inside or part of people prevents the externalization of the problem, this makes it difficult to find solutions (Hedges, 2010). The same could be said of focusing exclusively on the benefits of experiential knowledge of distress. There appears to be a need for a study that explores both these aspects with psychologists who have had such experiences.

### 1.8.2 The Benefits of Experiential Knowledge

It is sometimes asserted that people with personal experiences of distress make better therapists but the research literature on this is close to non-existent (Hayes, 2004). The positive effects on clinical work are thought to be increased identification, alliance, patience, hope, and reduced stigmatizing attitudes towards mental health difficulties (Cain, 2000; Gilroy et al., 2001; Gilroy et al., 2002).

One view in the literature is that clinicians who have personal experience of psychological distress have a wealth of expertise to draw on due to living and coping with such problems (Department of Health, 2002). This connects with the idea that the first tool of therapy is the therapist's own self (Elkaim, 1997). For instance, a client's story can resonate with our own, this can be a powerful experience involving bodily responses, thoughts, feelings and emotions (Hedges, 2010). This is relevant to those working within the reflective practitioner paradigm and those working within the frame of the scientist practitioner because the

evidence base highlights the importance of the therapist –client relationship on therapy outcomes regardless of the model that the clinician works within (Horvath et al., 2011). Resonance can be an invaluable tool and can help clinicians to create a unique bridge between themselves and the client (Hedges, 2010). It may also be useful to clinician’s colleagues who have not experienced such difficulties and the dilemmas they present (Department of Health, 2002).

It may be that this resonance can enrich and deepen a clinician’s connection to their clients (Cain, 2000). It has been suggested that the combination of psychological distress and the sense of isolation that accompanies these experiences results in the development of empathy for others in similar circumstances (Huynh & Rhodes, 2011). Similarly, it is thought that clinicians with personal experiences of psychological distress possess a heightened appreciation for how difficult therapy can be (Gelso & Hayes, 2007). As a result, they have more patience and tolerance when progress is slow, and greater faith in the therapeutic process (Gelso & Hayes, 2007)

In accordance with this, psychodynamically oriented therapists have stated that experience and successful resolution of psychological distress enhances the therapist’s empathic stance. This has been suggested by Fussell and Bonney, (1990) who state that the resolution of childhood experiences is thought to be important for maintaining an appropriate distance, one that ensures that the therapist does not become enmeshed in the patient’s problems nor avoids their pain. They suggest that the therapist can achieve this balance because they understand that recovery is possible.

## **1.9 Justifications, Aims and Research Questions**

As mentioned above psychologists report experiencing more personal problems in childhood and in their family of origin when compared to non -mental health professionals (Murphy & Halgin, 1995). The majority of studies that have explored this have been quantitative in nature and have used self-report



questionnaires (Katsavdakis et al., 2004). Additionally, the majority of studies have been based on samples of American therapists between the late 1980's and the early 1990's (Charlemagne-Odle et al., 2014). Furthermore, the therapist's own experiences of psychological distress have usually been conceptualised in the literature using psychoanalytic perspectives, no doubt an influence of the wounded healer archetype that dominates the field.

The literature also makes clear that there is a lack of phenomenological accounts of the process of acquiring a theoretical orientation (Rosin & Knudson, 1986). Due to this, there is a need for a qualitative study that explores the influence of distressing experiences that occur before training on the decision to become a clinical psychologist without using a particular theoretical model as a reference point. There is also a need for a study that explores this process using a UK sample of therapists. With regards to theoretical orientation, there appears to be a need for a study that considers whether experiences of psychological distress influence the theoretical orientation that clinicians work within.

### **1.10 Aims**

This study aims to produce research relevant to UK clinical psychologists and to trainers and employers of this group. It is hoped that the data presented will provide a useful insight into the perception of a sample of therapists regarding how experiences of personal distress influence the decision to train as a clinical psychologist and how these experiences influence the therapeutic orientation that individuals gravitate towards.

This is a neglected area in research and in routine clinical practice. This study aims to take an initial broad and exploratory approach. The intention is to move the conversations that may occur in private into a more public forum and in an attempt to combat the silence that stigma may be creating. In addition, hearing how clinicians make sense of their experience and its impact on them could provide further information on how employers can support clinicians and enhance

their existing strengths. This will add to the literature regarding personal experiences of distress from the therapists' perspectives, thus providing a useful starting point towards redressing the dominant discourse of deficit. The study may also provide evidence of the benefits and drawbacks of being a psychologist with experiential knowledge of distress as well as useful strategies for managing these experiences. Furthermore, the findings have potential relevance for individual psychologists, trainers, and managers of this group as it will invite them to consider how distress experiences influence personal and professional development, this could suggest specific questions for future research.

In response to the gaps in the literature, the proposed study is designed to explore the following research questions:

- How does experiential knowledge of distress influence the decision to train as a clinical psychologist?
- How does experiential knowledge of distress influence a clinical psychologist's preferred theoretical orientation?

## **2 METHODOLOGY**

This chapter outlines the methodology used in this study. It also describes the rationale for choosing a qualitative approach and situates this within the epistemological position of the research. Details of the researcher, participants, the methods employed in the data collection and the process of the analysis will be described.

### **2.1 Why Choose a Qualitative Approach?**

Qualitative methods deepen our understandings in areas where there is little current knowledge (Smith, Jarman & Osborn, 2009). They seek to explore experiences and aim to reveal a wide range of views. They also seek to produce rich, descriptive and contextually situated data. As a result of this, emphasis is placed on meanings and processes. As little is known about how experiential knowledge of distress influences the decision to train as clinical psychologist, an approach that allowed for exploration and discovery was thought to be the most appropriate. A qualitative approach was therefore chosen due to the focus on generating new theories (Willig, 2013). In addition to this, a qualitative approach allows for an observation of the historical and cultural systems that impact on the participant's world (Coyle, 2007), this is thought to provide some insight into the lived experience of participants.

### **2.2 Choice of Methodology**

A variety of methods could have been utilised in this study, however, Interpretative Phenomenological Analysis (Smith, 1996; Smith, Flowers & Larkin, 2009) was chosen as the most suitable method of analysis for this piece of research. An overview of each methodology will be provided and the rationale for selecting Interpretive Phenomenological Analysis (IPA) will be discussed.

Discourse Analysis (DA) (Potter & Wetherell, 1987) was considered for its interest in language. According to this methodology, language is used to construct experiences and social realities. It examines the linguistic resources that people use to construct accounts of experiences. This study had a different focus on linguistics and aimed to use participant's language to understand how they made sense of their experiences of distress in relation to their career choice. Due to this DA was thought to be inappropriate.

Grounded Theory (GT) (Charmaz 2011) was considered due to its focus on meaning making. It aims to develop theory based on the processes of social phenomenon. This is achieved through the use of a large heterogeneous sample and a bottom up approach which ensures that the theory of the phenomena is grounded in the data (McLeod, 2011). Given its aims, GT was not thought to be suitable as this study aimed to research a small homogenous group (clinical psychologists with experiential knowledge of distress) to understand how they made sense of their experiences rather than build a theoretical account of their experience.

Thematic Analysis (TA) (Braun & Clarke, 2006) is described as an atheoretical method as opposed to a methodology. It seeks to find patterns within data and to give in-depth descriptions of the dominant themes. The method can approach data in numerous ways due to its epistemological flexibility. A phenomenological TA could have been employed to explore what it is like to be a clinical psychologist with experiential knowledge of distress, however IPA allowed for a more nuanced, detailed analysis due to its idiographic focus and use of hermeneutics to understand how people make sense of their experiences (Smith, Flowers & Larkin, 2009).

### 2.2.1 Epistemological Position

This study approached the world from a 'critical realist' approach. This approach argues that human experience has a 'reality' which is situated within historical,

language dependent contexts (Madill, Jordan & Shirley, 2000). This position assumes that a reality exists for participants and invites the researcher to consider that in the context of this study, the meanings that therapists ascribe to the influence of distress on their career choice and development of their theoretical orientation will be mediated by their underlying thoughts, beliefs, expectations and judgements (Willig, 2013). The critical realist position is thought to fall between 'radical constructionism' which argues that there can be no observable realities or truths about the world because knowledge is socially and historically constructed and 'naïve realism' which suggests that objective knowledge can be obtained about the world because there is a knowable 'reality' (Madill et al., 2000).

## **2.3 Interpretative Phenomenological Analysis**

IPA is an experiential and inductive approach which explores how people understand their experiences of the world and the meanings they give to those experiences (Smith & Osborn, 2003). IPA has three theoretical underpinnings: phenomenology (study of experience), hermeneutics (process of interpretation) and idiography (study of the individual), these are used to explore the defining features of experience (Smith & Osborn, 2003).

### **2.3.1 Phenomenology**

Phenomenology was first proposed by Husserl, (1931) as a philosophical perspective concerned with knowledge. For Husserl, the founding principle of phenomenological enquiry is that experience should be examined in the way that it occurs and in its own terms. This requires identifying the essential qualities of that experience. Husserl reasoned that if this could be done then the essential qualities of that experience would transcend the individual's particular circumstances and illuminate a given experience for others (Dermot & Husserl, 2012). Getting to this level of detail involves stepping out of one's everyday

experience, a 'natural attitude' and adopting a 'phenomenological attitude' which involves a reflexive move, gazing inward towards one's perception of objects in the world (Smith et al., 2009).

Husserl invoked the term 'intentionality' to describe the relationship between the process occurring in consciousness and the object of attention for that process. In order to achieve the phenomenological attitude, Husserl developed a 'phenomenological method', which intended to identify the core features of human experience by "bracketing off" one's taken for granted ways of living in the familiar world in order to concentrate on the key features of the phenomenon known as the 'reduction' (Moran & Husserl, 2012). Ultimately, Husserl argued for a 'transcendental reduction' where one looks at the nature of consciousness in an attempt to get to the content of conscious experience by focusing upon experience itself and describing it in terms of its particular and essential features.

Heidegger contributes to this understanding of phenomenology by emphasising that it is not possible to make the reduction as observations are always made from one's own position, due to this he argues that the closest one can get to experience is through a hermeneutic lens of interpretation (Heidegger, 1962). Heidegger asserts that a hermeneutic lens is needed because one's being in the world is always in relation to something and thus interpretation of people's meaning making activities is central to phenomenological inquiry in psychology (Langdrige, 2007).

Merleau-Ponty and Sartre expanded upon Heidegger's work by introducing the focus on existence itself (Langdrige, 2007). Merleau-Ponty emphasised the embodied nature of our existence by stating that the body shapes the fundamental character of our knowing about the world. Due to this, Merleau-Ponty states that the lived experience of being a body in the world must not be overlooked or ignored in phenomenology (Langdrige, 2007). Sartre adds to this by discussing the notion of a person's worldliness in the context of personal and social relationships, i.e. one's perception of the world is shaped by the presence of others and the projects they are engaged in (Sartre, 2003).

In summary, Husserl's work establishes the relevance of a focus on experience and its perception (Smith et al., 2009). Heidegger, Merleau- Ponty and Sartre develop Husserl's work further by contributing to a view of the person as immersed in a world of language, culture, relationships and concerns. This moves phenomenology towards a more interpretative position with a focus on understanding an individual's perspective of their involvement in the lived world. In this way the researcher aims to capture something which is personal to the participant but which is also a property of their relationship to the world and others (Sartre, 2003). Thus in IPA research, the attempt to capture and understand other people's relationships to the world will focus on their attempts to make meanings out of the things that have happened to them (Smith et al., 2009).

With this in mind, the aim of phenomenological analysis is to broaden one's understanding of the phenomena being explored (Smith & Osborn, 2003). This stance aims to gain an understanding of an individual's experiences and the meanings that they make of these by exploring their subjective perspective of their world through describing the context and the manner in which these appear (Kvale, 1996). In taking a phenomenological perspective, the interrelationship between the researcher and participant is acknowledged thus the researcher's transparency and reflexivity is encouraged (Pope & Mays, 2006). This is thought to allow a recognition of the historical and contextual power imbalances that may exist between the participant and the researcher.

### 2.3.2 Hermeneutics

Hermeneutics is the theory of interpretation (Smith & Osborn, 2003). It is concerned with the way that meaning is developed through experiences (Smith et al., 2009). It highlights the dynamic relationship between the part and the whole of experience, highlighting the inability to understand one without the other. Hermeneutics recognises that in qualitative research, making sense of human experience is largely influenced by the researcher's subjective interpretations

(Smith & Osborn, 2003). This is illustrated in the concept of the 'double hermeneutic'. The double hermeneutic suggests that analyses are based on a questioning hermeneutic (critical questioning of what participants express and experience) and an empathic hermeneutic (understanding the perspective of participants) (Smith, 2007). Thus, attempts are made to understand the participant's perspective of their own "lived" experience. Due to this process, reflexivity on the part of the researcher is integral when attempting to use IPA.

### **2.3.3 Idiography**

The last defining feature, idiography focuses on the individual's experience by acknowledging that an individual can hold multiple perspectives on the same phenomenon (Barker, Pistrang & Elliott, 2002). Due to this, IPA is concerned with a systematic analysis of the detail of experience. Furthermore, IPA aims to gain an understanding of the experiences for specific people and the meanings that they attach to this. Consequently, IPA is not concerned about making generalisable claims about a population and it is more suited to small sample sizes selected purposively for novel areas of interest (Smith & Osborn, 2007).

## **2.4 Reflexivity**

Drawing on hermeneutic theory helps to demonstrate the role of the researcher in the co-construction of sense making and knowledge production with a participant (Larkin, Watts & Clifton, 2006). As such reflexivity is central to conducting an IPA study. In keeping with the method, it is important to consider this from the outset and throughout the research process. For this study a reflective journal was kept through each stage of the research process (please refer to Appendix A for an example of an entry).



#### 2.4.1 Personal Position Statement

As discussed earlier, the researcher's own biases, interests and assumptions will influence the process of qualitative research. This is because the researcher's own psychological processes (feelings, thoughts and experiences) and contexts (situational, personal, cultural and social conditions) will interact with those of the participant (Madill et al, 2000). As a result of this, reflexivity is an essential part of the research process and so some information is provided about the researcher in order to facilitate the reader's understanding of the researcher's position, so that this may be taken into account whilst reading this thesis.

The researcher is a 30 year old British-African Male, trainee clinical psychologist in his final year of clinical training. The researcher experienced feelings of acute anxiety, culminating in a panic attack prior to clinical training. Although this experience of psychological distress did not adversely disrupt his daily functioning, the impact upon his personal and professional life is considered by the researcher to be important. For instance, in clinical training he noted that there was an interest in personal and professional development as shown by the commitment in lectures and by the provision of reflective groups to explore the interface between personal and professional development. However, the researcher did notice that there was not a focus on clinician's personal experiences of psychological distress. Prior to clinical training, he had noticed that conversations about experiential knowledge of psychological distress occurred in private forums between clinicians but that these conversations were kept private. As a result of this, the researcher became curious about and interested in clinicians who have experienced distress and wondered whether these experiences influenced their decision to become clinical psychologists. This may be because the researcher was already on the career pathway to clinical psychology prior to his experience of psychological distress and so had not considered that "lived experience" of psychological distress might be an influence on the career pathway to clinical psychology.

## 2.5 Method

### 2.5.1 Participant Characteristics

Seven female and one male psychologist were recruited for the study.

Participants ranged between 25 and 49 years of age. Five of the participants were trainee clinical psychologists and three were qualified clinical psychologists. Eight participants has been suggested as an appropriate number to conduct a qualitative analysis that uncovered meaningful points of similarity and difference between participants (Turpin et al., 1997). All of the interviews were conducted in person by the researcher. During interview, in response to questions about personal experiences, participants described a variety of manifestations of psychological distress.

Table 1. Participant Demographics

Participant	Gender	Professional Status
Bonnie	Female	Qualified
Caroline	Female	Qualified
Elena	Female	Trainee
Freya	Female	Trainee
Hayley	Female	Trainee
Kathryn	Female	Trainee
Klaus	Male	Qualified
Rebecca	Female	Trainee

### 2.5.2 Participant Recruitment

An opportunistic sampling technique was adopted for this study. Participants were recruited via email and word of mouth. An opportunistic sampling method was chosen because it was thought that due to the stigma of personal experiences of psychological distress, it might be difficult to recruit participants. The researcher adopted this approach so that participants who were interested in being involved in the study might be contacted by or hear about the research through their acquaintances.

The approach consisted of sending emails to clinical psychologists in services that the researcher had been placed in for clinical training. As shown in Appendix B, the email urged psychologists to send information about the study to colleagues or acquaintances who might be interested in taking part. In addition to this, a link to a webpage with information about the study was made available so that the study could be advertised on social media (Appendix C). In response to the recruitment strategy, participants from the North and South Thames area made contact with the researcher by email to take part in the study.

Prior to the recruitment process, the researcher did not have any knowledge about the personal histories of participants, however, he had previously undertaken a six month clinical placement where two of the participants are employed. The researcher considers that this prior relationship may have influenced his desire to accurately portray and represent the accounts of the participants. This is discussed further in chapter 4 in the section titled *epistemological reflexivity*.

### 2.5.3 Inclusion Criteria

Participants were selected on the basis that they were trainee or qualified psychologists (clinical or counselling) who had experienced significant psychological distress prior to clinical training. The researcher clarified that 'significant' meant distress at such a level that it affected daily functioning and required the individual to seek support in the form of medication or psychological

therapy. All persons that volunteered for the study had experienced some form of psychological distress before clinical training.

#### 2.5.4 Interview Schedule

A semi structured interview schedule was used to facilitate the interview with participants. The interview schedule was designed to guide rather than dictate the process of the interview (Appendix D). Using an IPA method meant that keeping the schedule flexible was important as this places participants in control of the experiences that they reveal (Smith et al., 2009). The interview schedule utilised a series of open ended and closed questions. The questions covered a breadth of information about experiential knowledge of distress and theoretical orientation. These provided participants with the opportunity to share their experiences in an open, honest and in depth manner. Probes and follow up question were used where appropriate. Closed questions were also used to prompt participants, particularly if they interpreted the preceding open question as too vague or general.

Semi structured interviews are thought to produce rich data as a result of their flexible format (Smith & Osborn, 2003). It is thought that rich data is generated due to greater rapport and empathy being facilitated with participants. This rapport enables the participant to influence and direct the interview. As a result of this, there is an increased likelihood of novel areas in the research being highlighted by the participants (Smith et al., 2009).

#### 2.5.5 Procedure

Participants attended an interview with the researcher. All the participants were provided with a formal information sheet (Appendix E) to read so that they could provide their informed consent if they wished to take part in the study. The interviews took place at a mutually agreed venue. The interviews were audio-recorded using a digital recorder; the interviews lasted between 50 minutes and

70 minutes. A debrief occurred post interview, during this participants were given an opportunity to discuss their thoughts about the interview process. The debriefing conversations involved discussing the experience of being interviewed as well as issues that arose for participants during the interview.

#### 2.5.6 Informed Consent

Consent was received by asking participants to read through and sign a consent form (see Appendix F). The researcher answered any queries that participants had regarding providing consent. Participants were also reminded that they had the right to withdraw from the study at any time without disadvantage to themselves and without needing to give any reason.

#### 2.5.7 Confidentiality

Issues of confidentiality and how these would be addressed were outlined in the participant information sheet and discussed in person on the day of the interview. Participants were informed that the content of the interviews would remain confidential. The researcher made clear to participants that if they disclosed something that made the interviewer consider that there is a risk of harm to them or to others, it might be necessary to break confidentiality, inform other professionals in order to ensure the safety of participants and/or the safety of others. The researcher made clear that in this instance he would endeavour to involve participants in the safeguarding process that would occur as a result of such a disclosure.

#### 2.5.8 Participant Wellbeing

Prior to the interview commencing participants were informed that they could share as much or as little as they wanted and could decline to answer questions. Participants were informed that they could stop the interview at any time, take a break or re-schedule if they wished. Participants were invited to share their ideas

on how best they could let the researcher know if they were becoming upset and wanted to stop the interview or take a break. If participants had become distressed, the researcher would have offered support during the interview and would have provided a list of organisations to contact that would have offered further support.

## **2.6 Ethical Approval**

Prior to conducting this piece of research, ethical permission was gained from the University of East London Ethics committee (see Appendix G).

## **2.7 Analysis**

### **2.7.1 Data Transcription**

All recordings were transcribed verbatim by the researcher to gain familiarity with the data. Pseudonyms were used to replace names of participants and all other identifiable information was removed during transcription. A semantic level approach was adopted by transcribing the interview verbatim, as recommended by Smith and Osborn, (2003). Transcription conventions used in this study were adapted from Banister et al., (2011). Where words have been omitted in order to shorten quotes, this is indicated by dotted lines within rounded brackets (....). Repeated 'filler' words such as 'er' and 'erm' have been removed to improve the readability. In all extracts any identifying information has been changed to protect anonymity of participants.

### **2.7.2 Reflexivity and Record Keeping**

Notes were made about initial thoughts, reflections and observations which arose from the interviews. The notes included personal reflections about the participant-researcher dynamic and also any initial thoughts about emerging themes.

### 2.7.3 Procedure of Data Analysis

The following procedure describes a detailed analytic approach as recommended by Smith et al., (2009). This involves analysing individual transcripts before integrating themes across transcripts. The stages followed the process outlined below:

- In stage one, the researcher read the transcript whilst listening to the recording playing through earphones. The aim of this was to capture the experience of the interview and the participant. It also serves to ensure that the participant becomes the focus of analysis. The most striking aspects of the transcript were noted in a word document in order to bracket them off for a while. This stage involved reading and re-reading the transcript to develop familiarity with the text.
- In stage two, sections of the text were highlighted as points of interest arose. The researcher made exploratory comments in the right hand margin of the transcript. These included: descriptive comments (focused on describing the content of what the participant has said), linguistic comments (focused on exploring the use of language by the participant) and conceptual comments (focused on engaging the material at a more interrogative level by exploring the meanings conveyed by participants account). Different coloured pens were used to differentiate between these three levels of comments (see Appendix H).
- At stage three, the researcher transcript was read again and emergent themes were noted in the left hand margin. This involved an analytic shift to working primarily with the exploratory comments rather than the transcript itself. This process represents one manifestation of the hermeneutic circle because the whole of the interview becomes a set of parts as the analysis is conducted, this then comes together in another

new whole at the end of the analysis in the write up of the findings. The emergent themes were expressed as phrases which spoke to the psychological essence of the section whilst being grounded in the data. This involved attempting to produce a concise and pithy statement of what was important in the various comments attached to a piece of the transcript (See Appendix H).

- During stage four, the emergent themes were typed into a separate document and connections between them were explored. The list of themes were cut out so each themes was on a separate piece of paper, a large space (table top) was used to move the themes around and explore spatial representations of how emergent themes related to each other. Similar themes were clustered together and new themes were added as they arose. Themes that were in opposition to each other were positioned at opposite poles of a spectrum. This process involved going back and forth between the list and the transcript. The process also involved editing themes. Themes were re worded or new comments were added as further extract quotes challenged the current theme. Interpretations were continually checked to ensure that themes fit with the quotes that they originally arose from. Clusters of emergent themes were then labelled with a superordinate theme which attempted to capture the similarities in the group. This was then typed into a word document for each participant (Please see Appendix I). Part of this process involved removing themes that were not sufficiently evidenced in the text. Extracted quotes from each transcript, page numbers and transcript lines were noted alongside emergent themes in each superordinate theme cluster.
- Once each transcript had been analysed, the lists of themes was merged and patterns across cases were looked for. Each participant's table of emergent themes and superordinate themes was represented with a different coloured ink to make it easy to locate each participant when looking across cases. This involved laying out each table and looking for



connections or illuminations across themes. Themes were developed based on the richness of supporting data, their prevalence and their centrality to the research aims (See Appendix J). The final result of this process was represented in a table which showed how themes are nested within superordinate themes and illustrating the theme for each participant.

## **2.8 Data Checking**

One transcript which had been analysed was given to members of an IPA group to note identified themes. These were compared to the themes noted by the researcher in order to ensure that identified themes were grounded in the data. Broadly similar themes were noted and where needed themes were modified with this new information.

## **2.9 Dissemination**

The findings from the study will be written up for publication in academic journals. Furthermore, the study will be shared with services, organisations and professionals. A verbal or written summary of the research was also offered to participants.

### **3 RESULTS**

This chapter outlines the findings of the interpretative phenomenological analysis of the eight interview transcripts. Four superordinate themes were produced and within those a number of subordinate themes are presented. The arrangement of themes is listed in Table 2 below. Excerpts of the data will be presented to illustrate aspects of each theme. The researcher will hone in on relevant aspects of the extracts presented below. Further interpretation of the data, its relevance to existing literature and the assumptions held by the researcher will be elaborated on in the following chapter.

*Table 2: Themes Produced from Analysis of the Data*

Superordinate Themes	Subordinate Themes
How Experiences of Distress Influence the Career Pathway to Clinical Psychology	Influencing the Decision to Train as a Clinical Psychologist Influencing a Theoretical Orientation
Being a Professional Who Has Experiential Knowledge of Distress	Navigating Openness in the Profession The Idealised Psychologist Stigma in the Profession Lack of Visibility in the Profession
How Personal Experiences of Distress Influence How Clinical Psychologists Relate to Clients	Connecting with Clients Identifying with Clients Protecting the Self
How Distress Influences The Way Change Processes Are Understood	Turning Point Therapy as a Transformative Process

### **3.1 How Experiences of Distress Influence the Career Pathway to Clinical Psychology**

This first superordinate theme captures how participants made sense of the influences that shaped their journeys towards clinical psychology. Within this, the first subordinate theme, “Influencing the decision to train as a clinical

psychologist” captures how participants positioned distress experiences as a contributory factor to their decision to train as a clinical psychologist. The second subordinate theme “Influencing a theoretical orientation” comprises of participant’s ideas of how experiences of distress have influenced the theoretical frameworks that they currently find themselves attracted towards.

### 3.1.1 Influencing the Decision to Train as a Clinical Psychologist

Participants described multiple and varying influences that attracted them to clinical psychology. Some participants made a clear link between their experiences of psychological distress and their decision to train as a clinical psychologist:

Hayley: “I’m now a trainee clinical psychologist and going to qualify, I hope [laughter] in a year all you know, all things going well and I wouldn’t be doing that if I hadn’t had panic attacks” (5:173-176).

Hayley links experiencing panic attacks to the decision to train as a clinical psychologist. In the excerpt, she appears cautious and optimistic about her chances of finishing the training. Rebecca’s narrative about her attraction to clinical psychology is similar to Hayley’s:

Rebecca: “I think I’m quite interested in, I guess I have my own experiences that I had, that I’ve had, I had some treatment for, in mental health services for difficulties and I know that part of that has played out in the, my journey towards qualification and in my professional life”. (2:37-41)

However Rebecca highlights that this is only part of the picture for her:

Rebecca: “yeah I, and trying to think how to put it, I think it’s something I’ve had to make some peace with, I think part of my interest in psychology to some extent had stemmed from some of my own experience, I started having some issues when I was a teenager and it was around the time I got interested in psychology and I don’t think the entirety of it was about understanding myself and the difficulties I was having, but it did play a role, but then coming through training I’ve had a bit of time to reflect on that because I think I felt very concerned, almost not thinking about that I remember thinking ‘I don’t want people to think that the only reason I’m doing clinical psychology is a sort of introspection so that I can understand my own problems’ and that’s kind of a stereotype of, it seems quite a negative thing but I think actually, I can now accept that that is part of why

I got interested in clinical psychology, it's not the entirety of it, I'm not entirely motivated by some sort of self-exploration, it's probably part of the starting point". (2:67-84)

Here Rebecca indicates that she has gone through a process of making peace with her attraction to the profession which occurred as a result of her experiencing psychological distress as a teenager. She highlights that she has navigated a pathologising narrative about professionals with experiences of distress when she mentions 'a stereotype'. She concludes this excerpt by stating that she has reached a point of acceptance which appears to include the idea that her experiences of distress did play a role but are only a part, a starting point for why she chose to become a clinical psychologist. Clinical training appears to have been a catalyst for this process of acceptance.

Freya highlights her experiential knowledge of distress as an influence on her decision to train as a psychologist

MA: "I guess I'm just curious about whether or not those experiences have influenced your career choice, I mean you're a trainee clinical psychologist now so I'm just wondering about that?"

Freya: "I think it definitely, definitely did, I think, I think it probably only one part of the picture, if that makes sense but I think looking back on it, even, even quite soon after looking back on it, I did really think how different that might have been if I had been able to have help of some kind which, it's a tricky one cos in one sense I had that opportunity and I wasn't ready to take it but then maybe if it was offered in a different way or it didn't feel so kind of stigmatised or punitive or however it was felt at the time, maybe I would have accessed it and it would have been really helpful and made a lot of my teenage years much [laughter] better, so it definitely influenced my choice to do psychology". (2:60-76)

Similarly to Hayley, Freya stresses that this is not the only one influence on her career choice. In the extract above, Freya talks about being given opportunities to access help that she perceived as negative. From the excerpt, she moves from considering her career choice and talks about her relationship to help during her teenage years. She asserts that this influenced her decision to pursue psychology.

Elena's attraction to clinical psychology is outlined below:

“I’m really curious about why people do the things they do probably because I’d seen the damage that people do to other people and to themselves and how can things conspire or get out of hand unnecessarily and I’ve also seen when doing the job that I do, I was a support worker for a long, long time and things like that before I decided to become a psychologist, I can see how little things can make a big difference as well so you can nip things in the bud so that things don’t usually get out of hand, all these people with different lives don’t have to be hurt, damaged, I think that I, I hope that things can be different and I know that I’m very lucky and I’ve had lots of support and people around me helped me and helped me get on to different path and possibly I could have gone down another and you know and other people don’t have that so I suppose a part of my, the reason I like to do this work is to help people maybe give a bit of a hand to people who might not have those resources around them”. (3:85-102)

In the excerpt above, Elena talks about how people cause damage that can become ‘out of hand’ suggesting that the damage people do is uncontrollable in some way. She then talks about her work experience and how this influenced her decision to train as a psychologist. Here she talks about ‘nipping things in the bud’ which suggests a motivation to stop problems in their infancy. The repetition of the word ‘long’ in relation to her employment as a support worker appears to highlight that the decision to become a clinical psychologist came much later in her development. Elena concludes by highlighting the support that she received when she struggled with distress, she points out that other people may not have had these opportunities and so part of what influences her to do this work is to provide support for people who may not have the resources that she had available to her. In Elena’s account, distress appears to be a contributing factor to her eventual career choice but it features with other influences that Elena highlights in the excerpt above.

For Klaus, his attraction to psychology and then subsequently clinical psychology occurs on both a conscious and an unconscious level.

Klaus: “Conscious or unconscious? [laughter], [laughter]... so the practical journey, I’ll move onto the other in a second, the practical journey is I was thinking, ‘I want to be an English teacher’, I then flunk out in English literature O level, I flunk it, I get an E [laughter], thinking fuck I can’t do English A level. I could, but my confidence is not there so scrambling around looking for other subjects I want to do at A-level and there’s this thing called psychology, it looks kind of interesting, so I think , I’ll give psychology a go. So this is the conscious level and I love it, I really enjoy it, I really found it fascinating at A-level, I shone at it, I was very good at it, the A-level, and I thought about it, and I thought I really want to do a psychology degree, I want to do clinical psychology” (4:122-134).

In the beginning of the extract above Klaus signposts that there are two levels that he believes influenced his decision to become a clinical psychologist. He talks about how failing English at O level meant that on a practical level he was forced to think about another career pathway. Following this, he appears to discover 'this thing called psychology' and decides to try it out. There appears to be a juxtaposition between the urgency of finding a new career pathway and the casual way Klaus describes starting psychology. There may be many possible explanations for this, I am drawn to wonder whether framing psychology in a casual manner was a way to mask the anxiety that Klaus felt at the time. Following this, Klaus invites the reader to consider his intellectual fascination with psychology as well as his aptitude for it and how this led to considering a career in clinical psychology.

Bonnie talks about being attracted to Psychology because of a module that she had enrolled in at undergraduate level:

Bonnie: "In my final year there was a module on, it was psychology and culture but it was basically social constructionism and on the reading list was Michael White and narrative therapy, what was it?, narrative means to therapeutic ends and I remember reading that and being like, 'this is what the family therapy was, this is what they were doing' and there was something so amazing about not only being able to understand what it is they were doing and how it helped but also like the whole philosophy behind the approach and like, where it was coming from and why diagnoses can sometimes be unhelpful, so why I had such a reaction to me being diagnosed" (11:441-452)

In the above extract, Bonnie talks about how the module enabled her to make intellectual links between her experiences of distress, therapy and psychological theory. She describes going through a process of understanding how these areas were linked and that it enabled her to understand her reaction to being diagnosed with depression by her GP. Bonnie builds on this narrative by linking it to her interest in clinical psychology. This account is presented below:

Bonnie: "It was really, it was so exciting, yeah, and I think that's why I so wanted to go into clinical psychology because it was exciting and that idea of people having these, these rich stories because I'd always loved reading fiction and reading all the classic novels and always like I used to, God when I was younger, I wouldn't sleep because I was reading all night

long. There was something about what psychology is actually about, is about people's stories and yeah, and just thinking "Isn't that the most fascinating thing to get to know people stories". (12:469-477).

Here, Bonnie invites the reader to consider the excitement that she felt upon discovery narrative ways of working and its emphasis on people's stories. She then links this to her younger self and the enthusiasm that she had for reading fiction, she states that she would read "all night long" which gives an indication of her passion and eagerness to find out more about the stories that she was reading and highlights this passion for finding out about the rich stories of other people through clinical psychology.

Kathryn describes being attracted to psychology because it allows her to make meaning out of her experience of psychological distress:

Kathryn: "I think, there's something, there's something nice about trying to make the distress you've had a bit bigger than just you and not just thinking "oh, well that was something and I'm just going to put that in a box and I'm going to go and do something completely else" I think there's something quite nice about being able to take things out of that box on a very daily basis and think about them, I think it definitely helps me in my work with clients". (6:207-214)

For Kathryn, it is important to use her experiences and not to ignore them. She appears to be drawing on wider lessons from her experiences and to make meaning of them on a broader scale. She talks about how this helps her with her clinical practice when working with clients.

Within this subordinate theme, there were a subset of participants who cited early experiences of parents as influential in becoming a clinical psychologist. For instance, Klaus commented on the influence of his parent's involvement with mental health services:

Klaus: "I absolutely don't buy the idea that the decision was one made entirely at a conscious level because I was interested in it. The next question is why was I interested in it? What was it that got me interested in these things? It starts from a point that, there's no, to my mind, there's absolutely no coincidence from the fact that both my parents were also psychiatric patients and I end up working in mental health, you know, the



children of mental patients tend to end up in psychiatric hospitals one way or the other". (5:141-151)

Here Klaus highlights the inevitability of his eventual career in mental health. There appears to be an implication that the children of mental health patients become known to mental health services as clinicians or as patients. The way that Klaus talks about this influence appears to suggest an unyielding trajectory towards mental health services. In this extract Klaus again draws on psychoanalytic discourse about different levels of awareness of experience, he appears to draw on this to position his unconscious as a primary influence leading him to a career in mental health, this supports his claim of a predestined path.

Caroline also draws on her experience with her mother as an influence for her eventual career choice as a clinical psychologist:

Caroline: "I think if you're talking in terms of what experiences made me interested in getting into clinical psychology. I think, my mum, you know, she was a secretary, she is not trained in mental health at all, she's incredibly nosy but in a really good way just interested in people. For instance, at a family dinner on holiday you would see her looking at a particular table and she'd be like 'I think it's a second marriage and actually that daughter is from that one and blah blah blah, I think there's a bit of a difficulty with that relationship, blah blah blah' and then she'd go over, and start talking to them and be like 'yeah I was right!'. So she's very interested in people and I remember she would pick us up from school up to when I was becoming a stropky teenager, she would ask me questions about my day and "why do you think they feel that?", you know, the sort of things that she was interested in I think would have then shaped me up to me interested in that way". (7:248-263)

In this extract Caroline appears to present her mother as someone who naturally has skills in noticing and interpreting the dynamics between people, skills which are usually associated with the helping professions. Additionally, Caroline's mother is presented to the reader as demonstrating this insight with an unnerving accuracy and with such conviction that she feels comfortable approaching strangers with her ideas. There is a sense of Caroline's mother as a brave and bold figure. Inherent in the extract is the idea that Caroline's skills in mentalising and generating empathy for others started with her mother's interest in Caroline's

interactions at school with her peers through a process of socialisation. Caroline links these experiences as part of the reason that she became interested in becoming a clinical psychologist.

### 3.1.2 Influencing Theoretical Orientation

This subordinate theme captures the influences that participants felt led to the development of their current theoretical orientation. For instance, Caroline described multiple influences on developing a theoretical orientation:

Caroline: “It feels quite loose to me, I think that my experience influences my theoretical orientation. So my life experiences and my experiences of distress and therapy sort of thing ,as well as my experience of having worked in different settings, having worked with different clients, what I’ve read, who’s supervising me, what I’ve trained in. I’m also, I’m not a big fan of, I don’t quite like, I would never say I’m a CBT therapist or I’m a psychodynamic therapist or I’m a this, I’m that”. (11.456-463)

Caroline described her theoretical orientation as ‘loose’. She talked about a variety of influences that have shaped the way that she currently works with clients. She considers her experiences of distress as an influence but also stated that her experiences of therapy have been influential in developing her theoretical orientation. Caroline also references supervision, the clients that she has worked with, the literature that she has read, the training that she has received and the supervisors that she has had as influences. From this, it can be inferred that a number of influences have led Caroline to her current theoretical framework. The extract also appears to lead the reader to consider Caroline’s dislike of labels due to her perception of the limiting effects of this. This may reflect her desire to be without labels and her relaxed and “loose” approach to the models that she is drawn towards.

Elena also described multiple influences, such as the influence of parents, her experiences of distress and the context that she found herself in at the time. In addition to this, Elena identified as a social constructionist:

MA: "And I guess thinking about being social constructionist, interested in systemic ways of working and in community psychology, what do you, what do you think led to that?"

Elena: "Well, my experiences, growing up, my distress I think was changed by the people around me"...

MA: "And you said something about how your own experiences of distress were changed by the people around you, how did that happen?"

Elena: "Well, well I was a young girl with parents that argued and were a nightmare and it was a difficult environment to live in, I was quite anxious as a child then we left and my mom's side of the family are amazing, they looked after us, they didn't talk to me necessarily about problems but they cared for me, they were lovely to me, they understood if I had a tantrum, they never judged me, I felt secure with them and so they set me on a much better path and a much helpful one and if I'm upset it got sorted out as part of the family". (14:564-591).

Elena's account of influences on development of her theoretical orientation lead the researcher to consider Elena's perception of the power of systems. She talks about living in a "nightmare" in her parent's home and then describes living with her mother's family in a more positive light. The contrast from "nightmare" to "amazing" is quite striking and leads the researcher to consider the change in levels of anxiety that Elena would have felt in her new context. Elena goes on to talk about being loved and cared for by her mother's side of the family which infers that she didn't feel cared for in her previous family situation. She then talks about being set on a better path which may illustrate Elena's perception that her life may have been worse if she had stayed in her parent's home. Elena stated that problems were considered as a part of the family, this appears to have been a positive experience for her and appears to highlight the impact of systems, this may be part of the reason that she feels drawn to approaches that consider systems as the main vehicle for change.

Within this subordinate theme a subset of participants identified an attraction to systemic and psychodynamic ways of working. The attraction to systemic ways of working will be outlined first:

Hayley: "I'm interested in systemic because the more that I've worked with people especially young people I think, actually or adults, I've realised that it doesn't matter what you do with one person if they're in a system which doesn't change, then how can that person go out into the world and just then make changes?" (5:186-191)

In this extract Hayley comments on the wider scope that systemic approaches are thought to have, she draws on the systemic discourse with its emphasis on working with systems such as family networks. Hayley comments that her clinical experience has led her to believe that the family changes the individual's experience of distress. This appears to highlight the limits of individual change and allows the researcher to consider Hayley's belief about the impact of context. Hayley's clinical observation is similar to Elena's account of how a change in context influences the experience of psychological distress.

For some participants, the psychodynamic approach particularly resonated with personal experiences of core pain:

Bonnie: "I think because, I guess in narrative and systemic my understanding is that you're looking at people's strengths and skills and abilities and resources and then mobilising those.... Then I think, I think it doesn't offer a language or techniques for how to get into some of those core pain and I guess that's not what it's trying to do and there are good reasons for that.... using more psychodynamic ideas, I think that comes from my experience of being in really dark places at times, like crying and feeling really hopeless and so intensely sad about life and so intensely sad about losing my mum that I didn't know how to keep on going so I think yeah, a really rock bottom feeling". (13:501-522)

In the excerpt above, Bonnie compares her understanding of systemic and psychodynamic ways of working. She reaches the conclusion that systemic ideas are not applicable to working with what she calls core pain. Bonnie then talks about her feelings of distress when her mother died, she conveys the depth of emotion she felt and talks about a 'really rock bottom' feeling which the researcher interprets as Bonnie feeling as if she could not have felt any worse. She links this feeling of distress to the attraction of psychodynamic ideas because they appear to offer a way to work with these emotions that come from a 'dark' place.

As well as discussing their attraction to the psychodynamic approach, some participants expressed preference for the scope of psychodynamic therapy:

Rebecca: “I think, I think there’s something about the broader scope, there will be a focus of therapy but actually not needing it to be quite so focused in, maybe that is a little bit about me, my problems, that I felt like it wasn’t just one particular problem, it was a broad range and it often, it wasn’t, it was hard to pinpoint what to focus on and I see that in a lot of clients and so, I think that’s appealing”. (17.692-698).

Rebecca talks about the appeal of what she perceives to be the broader focus of psychodynamic approaches. This may reflect a dominant discourse where such approaches are positioned as more relational, deep and all encompassing. Rebecca then links this to her experience of psychological distress and her feeling that the problems she was navigating were broad and hard to pinpoint. Towards the end of this extract, Rebecca comments on the similarity that she sees in clients that she works with. When she talks about the “appeal” of this approach, the researcher wonders what Rebecca finds appealing about this approach. It may be that she perceives that this approach caters to many needs and presentations of distress. It occurs to the researcher that in this extract, Rebecca seems to consider the fit of therapeutic modality for broad problems but that she does not talk about outcomes or the usefulness of the approach. For Rebecca, it may be that scope and fit of the approach may take precedence over outcomes due to her own personal experiences of distress.

### **3.2 Being a Professional Who Has Experiential Knowledge of Distress**

The second superordinate theme captures how participants made sense of being a professional who has experienced psychological distress. Within this theme, participants considered how their personal experiences of psychological distress interacted with their professional identities. The first subordinate theme “Navigating Openness in the Profession”, considers the dilemma that participants face when considering how open to be about their experiences of distress. This appears to be influenced by the second subordinate theme, “The Idealised Psychologist”, the norm that some participants feel their competence is measured

against. The third subordinate theme, “Stigma in the Profession” reveals the stigma that participants perceive as occurring within the profession. This appears to be influenced by ideas of the “idealised psychologist” as well as by the final subordinate theme, “Lack of Visibility in the Profession” which highlights the participants’ understanding of the lack of positive role models, clinical psychologists who are open about their own experiences of distress within the professional context.

### 3.2.1 Navigating Openness in the Profession

This subordinate theme captures participant’s perceptions about the lack of openness in the profession about experiences of distress and their explanations for this. Some participants felt that it was difficult to be open about experiences of distress with colleagues:

Kathryn: “I think it’s one thing that I found quite surprising, I always thought that when I came into psychology that people would be much more open about their own experiences of distress and [laughter] and my experience has been that amongst, when you form friendships with people yes, but not within clinical psychology as a whole”.

MA: “and what do you think that’s about?”

Kathryn: “I think, partly, we get very conflicting messages as a professional body I think we, we get these messages about taking care of ourselves and the, but they are always laced with this “if you are not taking care of yourself then you are a danger to your clients and you must not practice if you are not well” (8.315-327)

For Kathryn there is surprise about the lack of openness about distress experiences amongst psychologists. Kathryn laughs when she makes this statement, as if she is laughing at the absurdity of the situation that she perceives in the profession. The researcher considers that the laughter is open to interpretation, another reason might be that Kathryn has become uncomfortable with the content of this part of the interview, the laughter may function as a way for her to manage the anxiety of the situation or to convey that the statements she makes in this section do not need to be taken so seriously. It may also serve to highlight the contradiction between her expectations of the profession and the

reality of the profession. Kathryn goes on to make an observation about openness in friendship groups but not in public forums, perhaps highlighting the contrast between a professional and a personal identity. When prompted about this she links this to systems level, particularly the conflicting messages that are communicated about self-care and safeguarding clients.

Freya states that she has noticed a similar process amongst psychologists:

Freya: "I think, I think also, I don't know, about the competence thing, I think there is this real sense among psychologists, I find real reluctance to share past experiences".

MA: "Why do you think that is?"

Freya: "It's a really interesting question, actually I feel that I should have a really together answer for that and I find that I don't particularly know, I really, you know, it's tricky isn't it because you think as a profession we should very much be advocating about being open about our experiences and reflect that those experiences have influenced the way that we are now and identify with our clients because we have all come with our own stuff [laughter] but I think that there is a real culture of, yeah of competence and not showing your weaknesses at all or your past experiences or if you do it has to be in a very together non- emotional way something if I have to bring something in supervision it has to be in a like "my thinking on that" and "my sense of it" and you know you can't get choked up or up all about those things". (8:313-331)

Freya's account of reluctance to share past experiences amongst colleagues brings to mind an environment of hesitancy. This caused the researcher to wonder what might be behind this, is it fear, distrust, ambivalence? Interestingly, Freya gives an insight into her experience at this point of the interview, highlighting that she feels she should have a 'together' answer. This may be because she may be sensitive to the expectations of her at this stage of her development as a trainee clinical psychologist, it also brings to mind the dynamic between the researcher and Freya and how this might be influencing Freya to want to supply the researcher with the right answer. As a result Freya might have been experiencing some anxiety about that.

Freya then links the reluctance that she perceives among professionals to a culture of competence within clinical psychology where one can't show weakness

or discuss past experiences. In contrast to this, is Freya's idea about advocacy and openness with clients, normalising experiences between clients and professionals as a requisite of the role. Freya then draws on the discourse of mental health problems as weakness and states that this discourse requires professionals to be distanced if they do choose to talk about their experiences of distress with others. This involves intellectualising past experiences and conveying recovery by presenting one's thinking about such experiences. Raw unprocessed emotion is framed as weakness and being unemotional is thought to display strength in Freya's account of this discourse. She uses 'choked' up as if to say you must not drown or be overwhelmed by your emotions. It is possible to infer that one must appear to "be together" when sharing past experiences with colleagues, it is interesting that Freya drew on this requirement when first providing an answer about sharing past experiences. Here we can see that although Freya notices and is critical of the culture of competence, she is also affected and directed by it.

### 3.2.2 The Idealised Psychologist

This subordinate theme captures the idea of an idealised norm against which other professionals are compared to and evaluated against. Elena's discusses this in the extract below:

Elena: "I wonder if there's kind of that professionalism, that kind of detachment perhaps in psychiatry that isn't quite the same with psychology but I do think there is a psychology persona and I'm not very good at it. So it's never saying what you think, you have to think before you speak and I'm not very good at that. You have to be quite controlled, I waffle as you can tell, you have to be quite intelligent and make sure that you can get all that theory, fit it all in the mind and use the skills and be on the ball. I think being in therapy is quite hard, you have to hold a lot of stuff in mind, you have to do things and I know that comes with experience, you can't kind of get swept along with your emotion, you can't be too emotional, you have to be controlled, you have to just about empathise without getting too involved, you can't go around crying all the time and you have to say certain words and just be a psychologist".(12.469-484)



In this excerpt, professionalism is framed as being detached, it is unclear whether that means being detached from clients, from your own emotions or your own experiences. Elena also claims that the detachment that she has observed is worse in psychiatry when compared to psychology. Here a taken for granted assumption appears to be that the practice of psychiatry is always detached. When Elena begins talking about the idealised psychologist, she uses the word 'persona', this brings to mind a mask, guise or façade. It is as if she is conveying that what is perceived by others when using the persona is false. Elena positions herself in contrast to this persona which leads the researcher to be curious about the function of this. For instance if the persona is fake, does that mean that Elena is 'real'?, more real and genuine than those who adopt the psychology persona perhaps? It could also connect to more general fears of being a fraud, an imposter psychologist. It is important to note that Elena also positions herself as lacking the attributes needed to don the psychology persona. The persona is conveyed as holding attributes that are necessary to perform the role of psychologist to a high standard. The idealised psychologist appears to be very balanced, doing neither too much or too little in terms of intellectualising and emoting. Elena says that you have to 'just be a psychologist', one interpretation of this is that she holds the view that some people can just be this 'psychology persona' and some people do not measure up to this but are more genuine.

Hayley talked about the idealised psychologist by considering it through the lens of discourses about the "impaired psychologist":

Hayley: "You know, the dominant discourse of society, people who have mental illness are faulty in their biology, and they're thought of as unpredictable, unreliable and difficult. I think there is still some of that, yeah maybe a lot of that idea or maybe a little, I don't know, the idea that if you had a psychologist who had experienced something like that, they would also, be unreliable, unpredictable and difficult to work with". (11.412-418)

Hayley comments on her perception of a dominant discourse in society that portrays people with experiences of mental health problems in a negative light. She suggest that this discourse influences clinician's perceptions of psychologists with similar experiences in an equally negative light. Hayley appears unsure

about whether her observation is accurate, this comes across in her hesitations before she then presents her idea to the researcher. In this extract there is a sense of an “impaired psychologist” which seems to be counterposed with the idea of the “idealised psychologist” (see aspects on pp 53-54). From the extract it is not apparent where Hayley feels these negative perceptions come from, her hesitation also leads the researcher to wonder where such perceptions may originate from if they were true. It may be that such observations are from examples seen in practice, they may also be perceived from the things that are not talked about openly in the profession.

### 3.2.3 Stigma in the Profession

This subordinate theme captures the stigma that some participants perceived as occurring in the profession, perhaps due to the perception of an idealised psychologist and its counter point an impaired psychologist:

Rebecca: “Yeah, I think because to some extent I think that it’s sort of my own stigma really, I don’t know that anyone is actually, I can’t tie it to anything that anyone said or that I’ve experienced particular stigma, I think I, I just worry that my sort of professional, my objectivity might be doubted by other people or I guess just that people would think that I’m not in the right place or stable enough to do the work which I think I am and I’m not someone to put myself out there for scrutiny”. (4.139-147)

Rebecca talks about the presence of stigma but from this extract it appears to be in the form of internalised stigma or the worry of possible stigma. She says that she has no specific examples to draw on but nevertheless the fear of stigma persists. Rebecca links this to a worry that her objectivity will be questioned by others. Inherent in this is the assumption that objectivity is valued by Rebecca and by others in the profession. It is unclear who these “others” are and how much power they have over Rebecca but they appear to be fairly powerful as there also appears to be a fear of them making judgements about her ability to practice clinically. Avoiding scrutiny seems to be Rebecca’s main motive where perceived stigma is concerned, she conveys this to the researcher when she says she’s “not someone to put myself out there for scrutiny”.

Elena also commented on her ideas of stigma in the profession:

Elena: “I think the stigma of society definitely exists in all of us whether we’re trained psychological therapists or any other mental health professional, we still carry that in us, where we think people are weird, or not good enough or damaged or “other”, it’s scary, you don’t want to be near, don’t want to get involved”. (11.437-443)

In the extract above Elena talks about her perception of a stigma discourse in society that exists within individuals. She frames this almost as an inevitable default state of being which results in positioning people as unworthy in some way. Elena states that specialist training does not negate this and goes on to state that being a mental health professional does not mean that you are without stigma thus implying that stigma permeates the profession in some way. In Elena’s account this results in the wish to be uninvolved in the affairs of the other and to stay away from them because of the fear that they generate within one’s self.

### 3.2.4 Lack of Visibility in the Profession

This subordinate theme captures the lack of role models and the lack of visibility that participants perceive in their profession:

Kathryn: “I wonder for our profession talking about personal experiences of distress, I kind of wonder where is it? I think there are a few examples of very high profile clinical psychologist who had quite extreme experiences but on the whole I think in general there are very few who are quite out. It could reflect my experiences at my course where actually the staff are very open with us but not I don’t think, so much in a completely public forum but I don’t know whether that’s so different at other training institutions but certainly in the NHS, supervisors never talk about personal experiences of distress in MDT’s or anything like that and I wonder, I wonder if the NHS is still stuck in quite a, where we just don’t talk about that and “we are the professionals, they are the patients” and there’s a line and there’s a wall there”. (13.517-531)

When Kathryn comments on the lack of role models in the profession, she begins by positioning professionals talking about experiences of distress as missing. This is conveyed by her asking the rhetorical question “where is it?” as if to amplify the effect of her comment. When she talks about role models, she

mentions her perception of a distinct lack of role models and their very high profile, it is as if their high profile means that they are untouchable or out of reach. Kathryn talks about the NHS context and positions the organisation as stuck or choosing to ignore the issue. The NHS is positioned as participating in an othering process between clients and clinicians. Kathryn talks about a line being there, almost like a warning line not to be crossed by either camp. She then describes a wall being there, an impenetrable barrier that is difficult to breach perhaps alluding to her perception of the unyielding nature of the NHS position.

Rebecca considers the lack of visibility in the profession in the extract below:

Rebecca: “I guess I have no, other than the people who are very open about it, I have no way of knowing how many people I work with, whether my colleagues have had experiences of, similar experiences, using services or maybe supporting someone else who has, I mean you’d imagine that most people had it if not themselves, then the experience of a friend or family member so in some way it is very personal to a lot of people but I don’t, I don’t have any way of knowing that or not”. (9.367-375)

Rebecca highlights her view of the contrast between professionals who are very open about experiences of psychological distress and those who are not open at all. She seems to have a query about the prevalence of distress amongst her colleagues but seems unsure about how to find out more about this. She appears to have a hope that the prevalence rates are higher than the lack of disclosure suggest when she says “you’d imagine that most people”, she then casts the net wide and includes experiences of friends and family members in what appears to be the wish to increase the odds of discovering experiences of distress amongst colleagues and their networks.

### **3.3 How Personal Experiences of Distress Influence how Clinical Psychologists Relate to Clients**

The third superordinate theme captures how participants’ experiences of distress influence the way they relate to clients and the emotions they experience as a

result of this. The first subordinate theme “Connecting with Clients” highlights how personal experiences of distress led the participants to connect meaningfully with clients. The second subordinate theme “Identifying with Clients” captures participants’ reflections on instances when connecting with clients appeared to move beyond professional boundaries and became unprofessional. The final subordinate theme, “Protecting the Self”, highlights the measures that participants take to maintain their recovery in relation to working with particular client groups or presentations.

### 3.3.1 Connecting with Clients

Some participants described the connection they feel with clients because of their experiences of distress:

Caroline: “Having had distressing things happen, I feel really connected with people. I do find it helpful in the work that I do, I’m not quite sure what it is, I thought you might ask me, I’m not quite sure how exactly and I would say that I feel like it’s, you know, all those kind of, what’s the word? clichés are so true, “what doesn’t kill you makes you stronger”, I really think it makes me less judgemental, it’s one of the elements to it.” (13.551-557)

For Caroline her experience of distress has led to her connection with people and with clients. The word ‘connection’ suggests an intimate knowledge of something about the other person which Caroline perceives to be helpful in the work that she does. Caroline’s excerpt leads the researcher to wonder whether the level of intimacy that she feels results from Caroline being non- judgemental with people. It occurs to the researcher that this is Caroline’s experience of this connection, this intimacy, the researcher wonders how clients experience this connection when with Caroline, what they would notice and whether they feel the same level of connection that she does. It occurs to the researcher that for the purposes of this study, the important thing is Caroline’s viewpoint of this particular phenomena. Caroline then draws on a well-known cliché, by doing this she may be attempting to demonstrate that she currently feels strong and has become stronger due to her experiences of distress.

Elena also commented on the importance of being connected with clients:

Elena: "I think, I think what's important in the work is, is about the connection with people, about being human with people about being warm and kind and having a therapeutic relationship with people and I think, we like to think that we have all the answers, that we know "this is going to work, that's going to work" which is very nice but I think there's a lot we don't know and I think the bottom line is just to be able to be with people and I think it, that for me that's really, really important and I think a lot of psychologists, not psychologists that's really unfair I don't mean like, I think there's a lot of hiding behind the intellectual stuff".

In the extract above Elena positions connecting with people as important. She then talks about her perception of what it is to be human with warmth and kindness featuring in this. 'Being human' is positioned as important and from this account it would seem that Elena is drawing on the positive aspects of being human, negative aspects of humanity do not feature in this, perhaps because Elena is talking about being human in the context of a therapeutic helping relationship.

In the excerpt, Elena contrasts being human with "being intellectual". She makes an observation about her view of a fallacy of certainty in the profession, she appears to regard this as nonsensical in some way particularly when she says "very nice" like what one might say to an ignorant child. Her way of dealing with the uncertainty of not knowing appears to be by placing value in being with people. She appears to value being with rather than doing to. This is apparent when she comments that psychologists hide behind intellectualising, she then retracts this statement. This causes the researcher to consider why the statement was retracted. It may be that Elena really did not mean it, it may also be because she felt that she has revealed too much in the interview and is unsure about the safety and confidentiality of the interview, the researcher considers that other interpretations may be made of this.

### 3.3.2 Identifying with Clients

Some participants commented on similarities between the stories they heard from participants and their own experiences of psychological distress. This is in contrast to the process of connecting with clients because identifying with clients is positioned as unprofessional due to it blurring the boundaries of the therapeutic relationship:

Hayley: “okay so if I have someone telling me a story which in a way matches onto something I think I might have experienced, my brain makes me think “I know how you feel”, but I don’t because that person is a different person to me and has experienced so many different things. We might have an overlapping similarity but it doesn’t mean I know how they feel”. (11.438-444)

Hayley comments that when she notices an experience that matches her experience of distress, it elicits a particular feeling. For Hayley, it is as if she “knows” the emotions of the other person. When Hayley says “something I think I might have experienced”, it brings to mind that maybe she considers that to others the experiences that elicit this knowing are not similar to Hayley’s own experiences. Hayley positions her brain as in charge of this identification process, it is as if the process is out of her control. This leads the researcher to consider the function of this. It might be that as a result of giving her brain agency in this context, Hayley does not have to take responsibility for this identification process. The reader can see that she goes on to regard the identification process as an inaccurate perception of a similarity between hers and the other person’s experience of their distress.

Some participants spoke about identifying with clients to such a degree that they felt obliged to rescue them:

Bonnie: “I found myself really, really wanting to rescue clients thinking ‘ gosh they are in distress and I know how awful distress is, I really want to make the situation better so they are not so distressed because it’s just horrible for them’, and you really see their pain and then sometimes that paid off and it meant that, I’ve got comments that clients were so appreciative that I’d gone the extra mile but at times it doesn’t work, I couldn’t rescue people because actually they didn’t want to be rescued”.

For Bonnie, the extract above alludes to an identification of distress with clients

She talks about wanting to save clients and minimise their distress. It is as if “seeing” their pain was experienced as painful for Bonnie. This led to her “going the extra mile”. Bonnie found that this worked at times and she would be singled out for praise, the researcher wonders whether Bonnie felt validated by this praise or if not what function it served for her. When Bonnie states her realisation that some people did not want to be rescued, it is unclear what emotions this provokes in her. It may be that she felt frustrated, or angry, conversely there may have been a sense of relief. Throughout the extract, Bonnie appears to invite the reader to consider the personal and professional development that has taken place as a result of her noticing the limitations of perceived similarities with clients.

### 3.3.3 Protecting the Self

Some participants highlighted an awareness of the need to protect themselves whilst working clinically:

Kathryn: “I think, that can be a downside too, knowing that you have this sort of chink in your armour and also perhaps there are client groups that you think that you couldn’t work with. I think I definitely have a sense of certain things that are probably just not good for me to work with”. (10.423-428)

Kathryn reports that she knows she has a “chink” her armour which can be thought of as indicating that she is certain that she possesses a vulnerability, limitation or weakness. The researcher considers what this means for Kathryn’s sense of self, her identity and how she feels about herself. Perhaps Kathryn is considering this as well because as she talks about this vulnerability she changes from speaking in first person (“I”) and continues in the second person (“you”). This might indicate that the content of the conversation is starting to feel too personal for her, she then switches back to first person as if to highlight her conviction in her final statement. It is interesting that she chooses to say “certain things” that she feels would not be good for her to work with as opposed to saying presentations, people, or client groups, perhaps this reflects that at this point she is considering the encountered or imagined problems that feel difficult



to work with as separate from clients. The shift in pronouns might also indicate that Kathryn is thinking about and broadening out her own experience, considering what others in similar positions might say or do. As ever, these are the researcher's interpretations and the researcher acknowledges that other readers may derive different interpretations from this excerpt.

Caroline also commented on the process of protecting herself:

Caroline: "I also think I have stayed away from working in areas, like I wouldn't have gone into eating disorders earlier, I myself also as part of the fall out PTSD developed a bit of an eating disorder, it wasn't a big one but it did, there are some areas where I wouldn't work with you know I wouldn't work in a traumatic stress clinic. I think I might really like to at some point but there's, I don't know if it a disadvantage or not because I think as clinicians you always have your areas that touch you more emotionally or that you just really aren't suited for you". (10.416-426)

Caroline talks about protecting herself by avoiding the eating disorders client group earlier in her career, this has now changed as she currently works in an eating disorder service. She links this to her experience of having had an eating disorder in the past and frames this as part of the adverse consequences of having had post traumatic experiences. The use of "fallout" appears to convey a sense that the eating disorder was particularly serious but then Caroline minimises this by saying "it wasn't a big one". Perhaps Caroline perceives the eating disorder as a more stigmatised condition and so minimises it, it could also be that the eating disorder was perceived as relatively minor due to the other phenomena that emerged as part of the fallout of PTSD. Towards the end of the extract Caroline normalises her experience by suggesting that other professionals have similar experiences in terms of areas that they choose not to work in because they feel too emotional. The researcher wonders about this and considers that Caroline's perception might be accurate, she might also be using this in a quest to minimise and normalise the anxiety she feels towards working in areas that feel overwhelming. Conversely, Caroline may be making meaning out of her experiences by considering the similarities between herself and other clinicians regardless of experiential knowledge of distress.

### **3.4 How Distress Influences the Way Change Processes Are Understood**

The fourth superordinate theme captures how participants' experiences of distress influenced a transformation in their perception of their life trajectory. The theme also captures the main process that participants said aided in this change process and the emotions they experience as a result of this. The first subordinate theme "Turning Point" considers how personal experiences of distress altered the life trajectory of participants. The second subordinate theme "Therapy as a Transformative Process" highlights how personal therapy acted as a catalyst for change in the lives of the participants.

#### **3.4.1 Turning Point**

Some participants commented that their experiences of distress were perceived as a turning point in their lives:

Klaus: "You finally get to a point of desperation, you finally, I found humility and got to the point where I say, 'I need help and I need to do something about this'. That was a turning point for me, moving forward and then part of the process for me was getting absolutely real, you know, no 'my mummy, my daddy did this to me' take some fucking responsibility. (11.470 – 475).

Klaus appears to describe desperation as if it is a destination on a journey. When he reached this "point of desperation" he was able to locate humility. From this account it appears that desperation provided an opportunity for Klaus, a turning point where he sought help. Part of this process appears to involve taking responsibility for his actions, in this section Klaus appears to be belittling or berating the aspect of himself that might blame his experiences of distress on his parents, this comes across when he says "no 'my mummy, my daddy did this to me", and is cemented when he exclaims 'take some fucking responsibility!'

The following extract illustrates Hayley's "turning point":

Hayley: “It turned out I’d had a really bad allergic reaction to the medication and we rang the GP and the GP was like, “yeah you should come off them, definitely just stop it, it’s really rare but some people can’t tolerate the medication”. Anyway, I’m telling you that because that was a massive turning point because after that, two weeks later I suddenly realised ‘I’m not depressed. What I’m having is panic attacks. I’m very sad and overwhelmed that I’ve had panic attacks but I’m not depressed’.  
(4.117-123)

Hayley describes having a rare allergic reaction to medication as a turning point for her. In the excerpt she claims that she came to a sudden realisation about her experiences of distress. From the extract, Hayley appeared to have found conviction in her own explanation of the distress experiences she had been experiencing. Perhaps the allergic reaction prompted the realisation that her GP might not have all the explanations for the phenomena that she was experiencing and this led to an increased reliance on her own ideas.

### 3.4.2 Therapy as a Transformative Process

Some participants commented on the positive impact that personal therapy has had on them. In the extract below, Bonnie comments on her experience of family therapy, specifically a reflection shared by her younger sister who was nine at the time:

Bonnie: “In this one session where she shared that because my brother who died was slightly older than her, where she shared that something that had been on her mind was that if he had lived then she wouldn’t have been born, and it was just the first time that her emotions had any space and with all of this conflict going on in the family, actually this was the conflict that was going on for her, and it was just so, it was just such an incredible experience, it was amazing and also I’d been caught up with my feelings and I think my dad had been caught up with his” (8.332-330)

Bonnie describes her lack of awareness of the conflict that her sister was navigating. Bonnie then talks about how the therapy process enabled her to discover her sister’s point of view because the space allowed emotions to be shared. Bonnie appears to be aware that she had been over involved in her conflicts and so had not been able to consider her sister’s dilemma initially. There

seems to be a sense that this revelation would not have occurred without the family therapy as a catalyst for this. Bonnie used the word “incredible” perhaps hinting at her perception of the magnitude of this revelation.

Kathryn also commented on the transformative process she encountered within therapy. Prior to this extract Kathryn had been commenting on the medical explanations for the psychological distress that she experienced:

Kathryn: “I suddenly had all these other constructions to put on it and “oh yeah, there was definitely a bit of that and a bit of that” but I still felt like they were quite unsatisfactory, and I think over time and going through personal therapy particularly, it just feels more like there are parts of myself that come from somewhere and a part of my story , it feels much more like a part of my story now rather than a thing that was happening or being done to me”. (3.92-99)

In the excerpt above, Kathryn appears to be describing her attempts to make sense of her experiences of distress. From the extract it appears that the initial explanations felt unsatisfactory but that over time and through therapy she has been able to integrate her experience as part of herself and her story. This process appears to have involved placing her experience in a context by tracing the roots of the difficulties. There is a sense that the distress experiences are now part of her narrative, there is also a sense that she perceives that she now has agency whereas before things were “happening or being done” to her.

## **4 DISCUSSION**

This chapter discusses the findings that emerged from the analysis discussed within the context of the study's research questions and the relevant research literature. This is followed by a consideration of the methodological issues and then a discussion of the clinical implications of the research. The chapter concludes with the researcher's reflections on the process of carrying out the study.

### **4.1 Research Aims Restated**

In response to the gaps in the literature, the proposed study was designed to explore the following research questions:

- How does experiential knowledge of distress influence the decision to train as a clinical psychologist?
- How does experiential knowledge of distress influence a clinical psychologist's preferred theoretical orientation?

The findings of these questions were captured in the superordinate theme "How Experiences of Distress Influence the Career Pathway to Clinical Psychology" which is presented and discussed below. This is then followed by a discussion of further themes that are reflective of the findings of the study.

### **4.2 How Experiences of Distress Influence the Career Pathway to Clinical Psychology**

The findings of the analysis suggested that participants experienced a number of influences as integral to their eventual decision to train as a clinical psychologist.

This is in contrast to the literature on the wounded healer (Jung, 1951), which highlights that a therapist is compelled to work with clients primarily because the therapist is also "wounded" in some way. However, the findings are also consistent with literature noted in chapter one which suggests that the view that psychologists are the bearers of psychic wounds is exaggerated and that their vocational calling is influenced by factors other than distress (Murphy & Halgin, 1995).

Some participants did make a clear link between their experiences of psychological distress and their decision to train as a clinical psychologist. (Murphy & Halgin, 1995). Furthermore, most of the participants talked about experiences of distress that occurred during childhood or in their teenage years which is consistent with research stated in chapter one that suggests that difficult experiences during these developmental stages influence the helping ability of individuals and leads to consideration of a career as a clinical psychologist (Wolgien & Coady, 1997) . For some participants, going through a process of accepting the influence of distress experiences on their career choice was part of their trajectory towards becoming a clinical psychologist. This was not an experience shared by all participants.

Within the data, there was some reflection on the relationship to help that participants had in relation to services and associated offers of help. The relationship to help is thought to include one's beliefs about the helping process that are brought to the clinical context - these beliefs are thought to significantly influence the process and outcome of a referral because formative experiences lay down the expectations associated with future offers (Reder & Fredman, 1996). Reflection on their relationship to help appears to have influenced some participants' decision to pursue a career as a clinical psychologist – their negative experiences of offers of help led them to want to offer something different to others in a similar position. This appears to be a neglected area of research. In addition to this, the importance of early detection and intervention in mental health problems and the wish to support others to receive this intervention was highlighted as an influence on the decision to train as a psychologist. Currently

there does not appear to be any research that is consistent with this, however there are recent government guidelines that suggest that there is increasing need for investment in services that support young people presenting with mental health problems (Department of Health, 2015).

One participant reported that unconscious choices played a part in the decision to train as a clinical psychologist. Explanations of the unconscious processes at work within and between individuals are usually framed within a psychoanalytic framework. According to psychoanalytic theory people choose a particular career due to the influence of significant childhood experiences, family dynamics, and familial vocational choices (Obholzer et al., 1994). The theory also suggests that unconscious determinants of vocational choice are internalised "objects" and "object relations" that reflect the individual's personal and familial history (Obholzer et al., 1994). Due to this, individuals choose an occupation that enables them to replicate significant childhood experiences and fulfil needs that were unfulfilled in their childhood (Malach-Pines & Yafe-Yanai, 1999). Furthermore, the theory suggests that individuals choose particular vocations in order to actualise occupational dreams, professional patterns and expectations passed on to them by their family of origin (Malach-Pines & Yafe-Yanai, 1999). This perspective highlights the differences in the sample because other participants did not talk explicitly about unconscious processes, although most were interested in psychodynamic ways of working. The researcher acknowledges that one cannot extrapolate too much from this one perspective but considers that it adds a new layer of inquiry when considering the multiple influences that the participants stated led to a career in clinical psychology.

Some participants said their intellectual affinity with the topics covered within psychology was an influence on their eventual decision to train as a therapist. There appears to be a lack of research in this area. It may be that the intellectual appeal of psychology has been overlooked in favour of more taken for granted factors such as childhood trauma, difficult family of origin dynamics and the wish to fulfil unmet emotional needs as noted in literature cited in chapter one (Farber

et al., 2005). Further research is needed to explore the influence of intellectual affinity in more detail.

Parents were reported to influence the trajectory towards becoming a clinical psychologist. For example, one participant commented on the interest that her mother took in her thoughts and feelings about the experiences of her peers during primary school. This is in line with research on mentalisation which suggests that children relate to the parent as an attachment figure and as a source of reliable information about the world (Fonagy, Gergely, & Target, 2007). Through this process of mentalisation it is suggested that the child constructs the sense of a subjective self, this occurs due to the caregiver's communicative displays which focuses on the child's thoughts and feelings (Meins et al., 2002). It may be that these repeated experiences of maternal interest led to the construction of a sense of self with an interest in the emotional material of others.

Within this superordinate theme, participants discussed the influences on the development of their theoretical orientation. The majority of participants suggested that they were influenced by multiple factors. One factor that emerged in the data was the influence of personal experiences of psychological distress. As noted in previous literature cited in chapter one, participants appeared to be drawn to models that were consistent with the way that their problems had been resolved in the past (Dryden and Vasco, 1991). Participants were also drawn towards models that provided the circumstances and techniques that they perceive led to the resolution of their own experiences of distress (Norcross & Prochaska, 1983).

Another factor that became apparent was the influence of supervision on the development of a theoretical orientation. This is in line with previous findings by Bitar et al., (2007) who stated that supervision provides teaching and modelling which enables therapists to explore different theories and select a model that is a good personal fit. Guest and Beutler, (1988) also commented on the influence of supervision and stated that supervisors provide important feedback and ask questions that shape the theory development process. Similarly, Murdock et al.,



(1998) commented on the supervision process and stated that the supervision process encourages clinicians to conceptualize the therapy process in different ways which leads to the integration of approaches into their preferred way of working.

As suggested by Bitar et al., (2007), family of origin and the difficulties participants experienced in this context were shown to be an influence on the development of a theoretical orientation. As noted in previous literature, for some participants, these experiences led to an attraction to systemic ways of working because this model supported them to resolve some of the difficult family of origin dynamics they experienced because of its focus on context (Vasco & Dryden, 1994).

In this sample, systemic and psychodynamic approaches were thought to be more useful ways of working compared to other approaches. Previous research by Scandell et al., (1997) suggest that individuals who have a preference for the unstructured and symbolic tend to be more drawn towards psychodynamic approaches whilst individuals who have a preference for more concrete and externally observable phenomena tend to be drawn towards systemic and cognitive behavioural approaches. There is currently a lack of research about the attraction to particular theoretical approaches, however as the participants in this study's preference for unstructured or concrete examples was not explored, it is prudent not to extrapolate too much from this finding. Further research might elaborate on this in future.

#### **4.3 Being a Professional Who Has Experiential Knowledge of Distress**

Participants commented that it was difficult to be open about experiences of distress in the profession. This may be because a core feature of the profession of clinical psychology in the UK is its adoption of the scientist-practitioner model (Division of Clinical Psychology, 2010). This appears to promote an expert model and has led to a perception of a "culture of competence" that appears to present

participants with a dilemma whereby they want to self-disclose but fear that it may be risky. This is because participants perceive that the culture in clinical psychology might position them as incompetent due to their experiences of psychological distress. Part of navigating this dilemma may involve conflicting tensions such as the tension of being fearful of exposure versus desiring a new understanding of the self from others (Starr, Ciclitira, Marzano, Brunswick, & Costa, 2013). It appears that participants attempt to resolve this dilemma by being open about their experiences of psychological distress in more private forums within the profession such as in personal therapy and within their respective friendship groups.

Within the professional guidelines, there is a recognition of the reciprocity between the impact of psychologists' personal lives and that of their clinical work (British Psychological Society, 2001), however as noted in the data this is often tempered with a reminder of the duties and responsibilities of the profession such as the obligation to monitor the impact of one's professional life on fitness to practise (Health Professions Council, 2009). Furthermore, clinical psychologists are statutorily obliged to self-disclose if the severity of the psychological distress they experience is impacting upon their professional competence (British Psychological Society, 2006b; Health Professions Council, 2008). These statutory regulations may further exacerbate the dilemma clinicians face as they struggle with the perceived punitive repercussions of disclosing past personal experiences of distress due to the sometimes conflicting messages of practicing self-care whilst safeguarding clients.

The researcher considers that it is not punitive to question someone's ability to practice clinically when they are experiencing psychological distress. However, as noted in the data and in previous literature, the pertinent issue is when one's own experiences of distress become the primary lens through which competence is closely scrutinised. For example, clinicians may not be currently experiencing distress but in instances where they show strong emotion, they may have their objectivity questioned as a result of disclosing past experiences of psychological distress (Kaslow et al., 2007; Kottsieper, 2009). It may be that further dialogue is

needed between statutory regulators, managers and clinicians with lived experience so that if they do experience distress that impacts on their professional competence, they will feel confident that the process and outcomes will have their best interests in mind as opposed to perceiving the process as punitive towards the individual and the clients they are working with.

Some participants commented on the idea of an “idealised psychologist”, a sort of perfect psychologist, an idealised norm that participants felt compared against. The idealised psychologist appears to be professional, neutral and knows to talk about experiences of distress in an emotionally distanced manner. These are characteristics that participants perceive that a good therapist possesses. As noted in the previous chapter, the construction of the idealised psychologist as professional, neutral and detached implies an opposite construction, a bad therapist or inappropriate psychologist named the ‘impaired psychologist’ in this study. The impaired psychologist is constructed as a clinician who is emotional, unreliable, unprofessional, has personal experiences of distress, and is lacking in interpersonal skills. The researcher considers that these constructions may be the result of a discourse of professionalism that presents the participants with the dilemma of trying to navigate openness whilst receiving cultural messages of what a ‘good’ psychologist should be like.

Due to this, the discourse of professionalism may exert a pressure on participants to distance themselves from their positions as psychologists with experiences of psychological distress through an implicit threat that such identities are somehow unprofessional (Callaghan, 2005). This polarisation of professional and non-professional within clinical psychology may function to relegate more politicised positions to the domain of the unprofessional. In this way, acquiring the authority to speak as the objective, neutral and homogenised idealised psychologist requires dis-identification with personal identities and experiences of psychological distress (Callaghan, 2006). It may be that participants are required to embody professionalism, and to keep their personal/political selves separate from their professional role in order to prevent them from seriously challenging

the identity of the idealised psychologist and the personal, professional and political ramifications of the construct (Callaghan, 2005).

As noted in previous literature cited in chapter one, participants perceived that mental health professionals including clinical psychologists held stereotyped beliefs and stigmatised attitudes towards people with experiences of distress (Jorm, Korten, Jacomb, Christensen & Henderson, 1999 ; Servais & Saunders, 2007) despite not experiencing any instances of discrimination themselves. It was also noted by participants that psychologists are embedded within a larger social context and are influenced by widely held social beliefs (Schulze, 2007).

When stigma was identified by participants, they commented that a feared consequence of stigma was that their competence and objectivity in their job role would be questioned, this is in line with previous findings (Kaslow et al., 2007; Kottsieper, 2009). In this sample of participants, stigma appears to originate from within and without, the two experiences of it are reciprocal and linked with societal pressures influencing the way that participants perceive the professional reaction to their experiences of psychological distress. There is a paucity of research on the influence of or the effects of stigma experiences amongst clinical psychologists who have experienced mental health problems, this may be elucidated by further research.

Some participants commented on the lack of visibility in the profession of psychologists who talk openly about their experiences of distress. Participants did comment on the visibility of high profile psychologists who have written about their personal experiences and were thought of as sources of inspiration (May, 2000; Perkins, 1999) but these psychologists were seen as out of reach and crucially were perceived as having disclosed personal experiences of distress at established points in their careers. This perception is important to consider as it appears that early in therapists' careers, and particularly during training, it feels riskier to disclose personal experiences of distress (Bloomgarden & Mennuti, 2009a; Sawyer, 2011; Stratton, Kellaway, & Rottini, 2007). There also appeared to be a wish for a template or guidance from role models about how to navigate

the identity of being a clinical psychologist with personal experiences of distress and how to disclose these personal experiences of distress. The researcher considers that this process may be like the coming out process for gay men and lesbians where individuals continuously navigate levels of openness and disclosure and may choose to be open about their experiences in one context and choose to be less open in a different context. In order for this process to be more comfortable, there would need to be a cultural shift within the profession so that individuals with personal experiences of distress may choose to be more open about their invisible experiences and identities (Gibbons, Butler, & Watson, 2005).

#### **4.4 How Personal Experiences of Distress Influence how Clinical Psychologists Relate to Clients**

Connecting with clients was a subordinate theme within this wider superordinate theme. Participants stated that their personal experiences of distress meant that they felt more able to experience warmth, empathy and kindness towards the clients that they encountered. This is consistent with previous research which suggests that clinicians with personal experiences of psychological distress show increased alliance, hope, and reduced stigmatizing attitudes towards people with mental health difficulties (Cain, 2000; Gilroy et al., 2001; Gilroy et al., 2002). It is also in line with previous literature which suggests that clinicians with experiential knowledge of psychological distress show greater empathy (Fussell & Bonney, 1990) as well as patience and tolerance when client progress in therapy is slow (Gelso & Hayes, 2007). As there is a lack of research into the positive effects of experiential knowledge of distress in clinical work (Hayes, 2004), this study adds to the literature for the clinical benefits of these experiences.

As noted in the literature, participants described the occasional tendency to identify with their clients to such a degree that they felt the need to rescue them. In the literature, this process has been termed 'over identification' and is thought to be an extreme form of identification with clients to a degree that the therapist

loses perspective on the therapeutic process (Zerubavel & Wright, 2012). One explanation for the occurrence of this process is that it may occur due to the therapist projecting their difficulties onto the client (Briere, 1992; Gil, 1988). Alternatively, this dynamic may be explained by thinking about what is communicated between clients and clinicians with experiential knowledge of distress. For instance, it may be that clients communicate helplessness due to the difficulties that they face. In response to this clinicians may notice that this resonates with their experiences and they may feel compelled to act (Holden, 2013). It occurs to the researcher that it may be difficult to distinguish between support which is appropriate and rescuing which is deemed as inappropriate. Some participants appeared to learn to notice the difference over time, particularly as they gained more clinical experience but would this look the same for all clinicians?

Another explanation may be that participants are engaging in a process whereby they exaggerate the similarities that they perceive between themselves and their clients. This may cause clinicians to connect deeply to or to over identify with the struggles, situations, difficulties and dilemmas that their clients face. Tajfel, (1974) describes this as a normal cognitive process that individuals undergo in order to create a shared social identity and to maintain individual self-esteem. This may be a process that occurs between therapist and client in the clinical encounter. Perhaps clinicians become more aware of this process and its impact as they gain clinical experience.

Protecting one's self was another subordinate theme within this superordinate theme. Some participants noted that their experiential knowledge of distress meant that they avoided working within particular services and with particular client groups in an attempt to protect themselves and to maintain their recovery. Although this finding appears to 'make sense', perhaps reflecting a taken for granted assumption about how clinical psychologists attempt to self-care and maintain recovery, there appears to be a lack of research into this area. Perhaps future research could consider how clinician's with experiential knowledge of distress attempt to protect themselves and maintain recovery in clinical practice.

#### **4.5 How Distress Influences the Way Change Processes Are Understood**

Within the data, participants commented on how times of crisis offered opportunities and turning points that led to a different more positive life trajectory. This view does not appear to be supported heavily in the literature. This is surprising especially when it could be argued that this is an idea central to the existential-humanistic tradition of psychology (Joseph & Linley, 2006).

Participants also commented on the effect of personal therapy, as a way to make sense of their experiences of distress by integrating personal and professional aspects of their identities. This is consistent with previous research as noted in chapter one, which suggests that psychologists navigate these dilemmas by taking part in personal therapy (Dearing et al., 2005), it is also in accordance with studies that suggest that therapy facilitates personal growth following distressing experiences (Joseph & Linley, 2006). Furthermore, the process of therapy is thought to develop one's emotional intelligence which is said to be part of the repertoire of clinicians who are developing personally and professionally in their roles (Goleman et al., 2003). In addition to making sense of experiences, being able to hear and take on the perspective of others was thought to be a useful aspect of therapy. This may be because personal therapy offered participants the opportunity to have an experience of being a client as suggested in previous literature (Rake, 2009).

#### **4.6 Critical Review**

The current study has produced some interesting findings which have both challenged and supported the existing literature. It has also provided new findings by focusing on a specific group, which has been under researched in the UK within the context of how their personal experiences of distress have influenced

their career choice and preferred way of working. However, it must be acknowledged that the study had some limitations. Furthermore, qualitative research particularly can create challenges as discussed below. It is important to focus on and be aware of such issues. Through reflexivity, a central factor to qualitative research, these issues will now be considered.

#### 4.6.1 Sample

A decision to adopt an opportunistic sampling method was made for practical reasons; to gain participants who were immediately available and freely consenting to participate. The sample was primarily female, perhaps reflecting a growing global trend where women psychology trainees substantially outnumber men in postgraduate psychology programmes (Callaghan, 2006). Additionally, all participants identified with a White European ethnic identity. It is acknowledged that a more systematic approach, such as advertising and marketing for participants for a longer period of time and actively seeking out targeted representation in terms of ethnicity and gender, might have yielded a participant sample whose data may have been richer. The study also obtained a small sample from a specific geographical area, therefore the findings may not be representative of other clinical psychologists living in the UK. The findings cannot be considered generalisable, however it is important to note that this was not the aim of the study. By using a qualitative methodology one of the aims was to capture the uniqueness and diversity of participant's lived experiences.

The sample was homogeneous due to the perspective that participants were representing (i.e. experiential knowledge of psychological distress). The sample consisted of a mixture of qualified and trainee clinical psychologists, however, the majority of participants were in their final stages of clinical training. The researcher acknowledges his concerns that their time was pressured by professional engagements, such as conducting their own research projects as well as to other commitments required of trainees. Although the informed consent process was very clear about the research study, it is possible that they simply did not have the time to reflect on their experiences, as required in the interview.



The same could be said of the qualified psychologists in the sample due to the demands of managing larger caseloads as well as more complex clinical duties and responsibilities.

With this in mind the researcher would spend more time at the beginning of the interview to set the scene and give participants a chance to become accustomed to the encounter. The researcher considers that a mindfulness exercise prior to the interview may be useful in guiding participants to focus on the present moment, if needed. The researcher also considers that one advantage of this sample is the breadth in terms of training, clinical experiences and personal experiences of distress that may have contributed to the richness of this study.

#### 4.6.2 Methodology

It has been argued that IPA cannot directly or completely access the lived experience of participants (Smith et al., 1999). This argument is centred on IPA's grounding in phenomenological philosophy, which is thought to overlook the complexities in truly knowing the content of individual experiences. The criticism also questions the role of the researcher and their biases which are thought to influence attempts to analyse the data.

In response to this, it could be argued that the approach assumes that participants attempt to communicate the truth of their experiences during the research interview. It could be argued that the approach considers this criticism and responds by acknowledging the researcher's active involvement and subjectivity in analysing the data (Smith & Osborn, 2003). Hence the importance of reflexivity and openness on the part of the researcher. In this way the researcher's biases, assumptions, interests and the influence on the interpretation of the data is accepted.

#### 4.6.3 Data collection: Semi Structured Interview

Potter and Hepburn, (2005) argue that semi-structured interviews are used unquestioningly by researchers when conducting qualitative studies. This issue centres on whether the interview is discursive and so needs to be understood in and of itself or whether interview data is a resource by which experiences can be analysed in order to reach an understanding of them (Reicher, 2000). This critique of the interview method can be divided into aspects which are inescapable when conducting interviews and aspects that can be rectified during the interview process (Potter & Hepburn, 2005).

Rectifiable aspects include; underanalysis of interview data through the lack of explicit claims made of the data, inadequate referencing of interview data, presenting limited information about the interaction within the interview process and lack of detail about the fuller context of the interviewee's journey into and through the process. Inescapable aspects are thought to be: the biases and agenda of the researcher, the conflicting treatment of interviewees as neutral informants and the lack of clarity around different positions the interviewee and interviewer adopt or are placed in at different points in the interview (Potter & Hepburn, 2005). How these aspects were considered in light of this current piece of research is further discussed in this chapter under the heading 'Quality of Research'.

#### 4.6.4 Reflexivity

Personal reflexivity refers to how a person's values, beliefs, acquaintances and interests influence his or her research or work whilst epistemological reflexivity attempts to identify the foundations of knowledge and the implications of any findings (Willig, 2013). In this section, the researcher will discuss his personal and epistemological reflections. In addition, the researcher will discuss how this reflexive process influenced the study.

#### *4.6.4.1 Personal reflexivity*

In the methodology section the researcher highlighted his own position which will have influenced the research process, namely as a trainee clinical psychologist who identifies as having experienced psychological distress. Thus the researcher shared some similarities with the participants of the study. Some have pointed to the benefit of researchers studying groups of which they are similar to (Egharevba, 2001). At times, the researcher felt that his similarities with the group helped the research process, he had a sense that participants felt at ease with someone who had a shared desire of wanting to highlight a group that were under-researched and therefore under-represented in the literature. From the beginning of the project, the researcher considered his stance towards the subject matter in the study and endeavoured to bracket off his own prior experiences and assumptions about how participants might present their accounts.

One of the rationales behind the current study was to research a group underrepresented within the evidence base. In wanting to highlight the experiences of clinical psychologists with experiential knowledge of distress, the researcher did not want to label this specific group as different or other. He realised how this in itself could create unhelpful discourses about this group. Throughout the research process, the researcher considered the impact that this piece of research might have on the clinicians concerned and the group they considered themselves to be representing. Throughout, the researcher considered how he might be positioning clinical psychologists with personal experiences of distress and how this might be perceived by others.

As a trainee interviewing other trainees, the researcher was initially concerned that participants would be fragile in some way, due to this he had safeguarding the participants at the forefront of his mind for the first few interviews. Safeguarding participants remained at the forefront of the researcher's mind but the anxiety about this lessened as he gained experience interviewing and as a result, a perception of robust, resilient individuals developed following each interview. The researcher noted that each interview left a strong impression on

him as he encountered people with some similar experiences that resonated with him such as the wish to try to make sense of experiences of distress within a professional context.

As a trainee interviewing qualified members of staff, the researcher felt pressure to be professional and to provide a “good interview”. Despite reflection on this, the researcher is unsure what a good interview would have looked like but he did consider where this pressure was coming from. It occurred to the researcher that at the time of interviewing, other trainees in his friendship circle were interviewing clinical psychologists for their own research projects. There seemed to be an idea that these psychologists, participants in the research project could in future be colleagues, supervisors or employers and due to this, it was important to demonstrate competence. The researcher also considered that through the process of the interviews, he would learn personal information about clinicians that he might meet again in personal or professional circles. The perception of the power imbalance in this was uncomfortable for the researcher. As a result he tried to redress this during the debrief following the interview by providing background information about his interest in the study and also by providing some details about his own experiences of distress. In hindsight, the discourse of professionalism may have been exerting pressure on the researcher as he found himself caught between wanting to be professional but also wanting to be congruent with his own values about connecting with people, showing warmth, empathy and being genuine. With this in mind, at the time the researcher was mindful of how much of his “non research self” he could bring into the interview without contaminating or distorting it (Glensne & Peshkin, 1992) but he made the decision to stay true to his core values and used these in the interviews.

#### *4.6.4.2 Epistemological reflexivity*

As noted in chapter two, IPA analysis requires the researcher to analyse on three levels; descriptive, linguistic and conceptual (Smith & Osborn, 2007). The researcher noticed that during the analysis he was drawn more to the linguistic aspects of the participants’ transcripts, perhaps because they seemed to provide

a window into their perceptions and lived experiences. Following supervision, he found that he was able to highlight the conceptual aspects of the participants lived experiences by considering what the experiences appeared to mean for them as well as by considering what was underlying the experiences that participants were trying to convey in the interviews and subsequent transcripts.

During the analysis and when writing the results chapter the researcher noticed that he had concerns that the interpretations he was making from the data might not resonate with some of the participants in the study. He also had concerns that participants may feel that he had portrayed them in a negative light. Furthermore, the researcher felt a conflict between considering what he felt the participants wanted to get across and reporting the findings according to his own interpretations and familiarity with the literature. This may have felt particularly pertinent because the researcher had prior professional knowledge of two of the participants. Perhaps the interface of professional and personal knowledge was creating the conflict that the researcher felt. It could also be that the researcher's own experience of psychological distress caused him to assume that the participants would want him to portray a balanced accurate picture of their experiences.

In response to this, the researcher made certain that the interpretations were grounded in the data, he also endeavoured to consider different perspectives when analysing the data. These considerations highlighted the power researchers have in deciding what gets selected as relevant for interpretation and then subsequently reported. The researcher at times questioned his epistemological and theoretical assumptions and considered how different the participants accounts and thus findings from this study would look if a different methodology had been employed.

#### 4.6.5 Quality of the Research

Yardley, (2000) argues that there is a need to evaluate the quality of qualitative research. This is made more difficult due to the different epistemological positions

that different qualitative approaches adopt. It has been suggested that the evaluation criteria used for any piece of qualitative research should fit the particular method that has been adopted (Madill et al., 2000). Due to this, the present study will adopt the seven criteria by Elliot et al., (1999) as an evaluation framework. The criteria and the attempts made to meet them are noted below:

- Coherence - The researcher is required to present a coherent and integrated analysis. This is addressed by outlining the analytic process which resulted in an order of themes. The links between the themes and interview data are discussed (in Chapter three), both of these are then discussed in relation to previous literature in this chapter.
- Grounding in examples - This criterion requires the researcher to demonstrate the analytic procedures used and the understanding generated. This is achieved by providing clear examples from the data. Furthermore, quotation extracts are used to illustrate the themes generated (in Chapter three).
- Situating the sample - requires the researcher to describe participants in some detail to allow the readers to assess the relevance of the sample and the applicability of findings. This is provided under the heading 'participants' (in Chapter two) and described in the analysis of the themes (in Chapter three).
- Accomplishing general versus specific research tasks – The researcher is required to be clear about the procedure and about the specific research tasks. These are identified in Chapter one, Chapter two and are reviewed in more detail in light of the analysis in Chapter four.
- Owning one's perspective - requires the researcher to disclose their own assumptions. This allows the reader to interpret the analysis and consider their own alternative interpretations. Perspective owning is addressed

under the heading 'personal position statement' (Chapter two) and in "Personal reflexivity" and "Epistemological reflexivity" (in Chapter 4).

- Resonating with readers - This criterion invites the researcher to present the material in a way that allows the reader to feel that the research has expanded their understanding of the subject being investigated. In order to provide this, a coherent structure has been adhered to whilst writing this study so that the reader can develop their own reflections of the study as well as an understanding of the existing literature and the process and outcomes of the findings of this current study.
- Providing credibility checks – requires the research to refer to the interpretation of other's when they investigate the data. Members of an IPA group checked some of the transcript data for evidence of related themes. The researcher has also provided details of the audit trail of the analysis (see Appendices H, I and J).

## **4.7 Implications of the Research**

The findings from the study have implications for clinical practice, training and research. These will be discussed below.

### **4.7.1 Clinical Implications**

This study highlighted that most participants placed value on their ability to connect with clients through the use of empathy and a non-judgemental stance. They attributed this to their previous experiences of psychological distress. This is consistent with previous research which suggests that experiences of psychological distress and the sense of isolation that accompanies these experiences result in the development of empathy for others in similar circumstances which may lead to a deeper insight regarding the nature of the

client's struggles (Calhoun and Tedeschi, 2008; Fussell and Bonney, 1990; Huynh and Rhodes, 2011; Zerubavel and Wright, 2012). Skills such as congruence - the willingness to relate to clients, unconditional positive regard - the therapist's willingness to attentively listen without judgement and empathy - the therapist communicating their desire to understand and appreciate their clients perspective are hallmarks of the person centred approach to psychotherapy (Rogers, 1957).

In recent literature, these have been termed *common factor skills* and are thought to be integral in any effective encounter between a client and a clinician because they result in the development of a strong therapeutic alliance (Richards and Whyte, 2011). As the evidence base highlights the importance of therapist –client relationship for good therapy outcomes regardless of model (Horvarth et al., 2011), the clinical implications of this are that these skills should be highlighted as useful, with further training offered in developing them further, in an effort to build on the skills that participants demonstrate as a result of their experiences of distress.

Participants also talked about identifying with clients in such a way that was felt to be negative. It occurs to the researcher that supervision may provide clinicians with the opportunity to explore this experience. However, this would only be made possible if supervisors create an environment where it feels safe to discuss these experiences. This could be achieved by normalising the experience and may then result in new knowledge about the useful and less useful aspects of identifying with clients.

#### 4.7.2 Professional Implications

The professional culture within clinical psychology was portrayed by participants as potentially problematic in terms of creating and propagating the construct of an idealised psychologist. This suggests that a cultural shift is required in order to reconceptualise the profession's ideas of what it means to be a psychologist with experiential knowledge of distress. Any connotations of it being synonymous with



vulnerability, weakness or failure should be discouraged in line with the accreditation criteria for clinical psychology programmes which calls for diversity within the profession (British Psychological Society, 2008). Furthermore, clinical psychology may benefit from more explicit formal guidance, perhaps a position statement in relation to the profession's stance on supporting professionals who have experiential knowledge of distress.

There is an indication of the British Psychological Society's, (2006) stance on professionals with disabilities in the form of good practice guidelines which has some references to psychological distress. The document offers guidelines for creating a more positive and respectful culture within the profession, these include: considering the professional culture and its effects on creating welcoming environments in personal and professional development modules, giving a positive message about support for professionals with mental health problems, promoting positive role models of clinical psychologists with a range of disabilities, being careful to use inclusive language when talking about people with experiences of distress and encouraging staff to give some thought about how to model talking about their own mental health experiences in a considered manner.

The document is a starting point for changing the culture of the profession but it does appear to foreground issues of physical disability perhaps because there has been more literature in this area. In addition, psychologists with personal experiences of distress may not consider their experiences as a disability. With this in mind, the development of a document that caters for and considers the issues pertinent for clinicians with experiential knowledge may be useful for clinicians, their colleagues, supervisors and employers.

#### 4.7.3 Research Implications

The findings from this study have prompted the researcher to consider the implications of this study for future research. Some of these considerations are discussed below:

Within the data, some participants mentioned that at times they identified with their client's distress and even felt the impulse to rescue clients, though this did change over time. This prompted the researcher to consider the prevalence of this experience amongst clinicians with experiences of distress and how they make sense of this experience. It also prompted the researcher to think about the influence of the cultural context of clinical psychology and to question the notions of "identification" and of "rescuing" as these tend to be framed in a psychodynamic and somewhat pathologising manner. Future research could explore this and also investigate how clinicians differentiate between rescuing and offering appropriate support. This may be useful in normalising the process of identification and may shed light on the creative ways that clinicians manage this and use it in their therapeutic work. A different methodology, such as discourse analysis which attends to language, historical and cultural contexts might be able to explore these stories more easily.

The subordinate theme "protecting the self" was developed as a result of some participants stating that their experiences of distress meant that they chose not to work with particular client groups or avoided working in particular services as this was perceived to be beneficial for their maintained recovery. This led the researcher to wonder how clinicians with experiential knowledge of distress protect themselves and maintain their recovery. The researcher considered that choosing to avoid working in particular services and with particular client groups could be thought of as practicing self-care. With this in mind, further research could elucidate what protecting the self means and what actions or practices clinicians perform to enact this. The researcher also wonders what clinical guidance, theoretical models or local knowledge that clinicians draw on when they talk about the decision process as well as the reasoning that they offer for the self-care practices that they perform. An alternative methodology such as grounded theory which is said to construct theory through the analysis of data may be able to explore this and offer a theoretical framework of the self-care process that clinicians with experiential knowledge of distress go through in order to feel protected in their professional role.

## **4.8 Conclusion**

This study aimed to explore the perceptions of a sample of psychologists regarding how their experiences of psychological distress influenced the decision to train as a clinical psychologist. This piece of research also aimed to investigate how these experiences influence the therapeutic orientation that individuals gravitate towards. These particular areas have historically been neglected within research.

Using an IPA analysis, four main themes were evident in the participants' accounts. Consistent with previous findings were the themes of psychological distress influencing theoretical orientation and the decision to become a clinical psychologist. The study was also supported by previous research findings that state that family of origin difficulties influence the decision to train as a clinical psychologist and also by findings that acknowledge the impact of stigma that is perceived to exist in the profession. The study highlighted new themes such as the idealised psychologist, the perception of a lack of role models with personal experiences of distress and a lack of guidance about how open to be about experiential knowledge.

The findings of the study had clinical, professional and research implications. Clinical implications included highlighting the strengths that clinicians bring to therapeutic practice. Professional implications included affecting a cultural change so that the profession is more welcoming and inclusive of people with experiences of distress. Research implications included exploring how clinicians make sense of identifying with clients in clinical work. The researcher's hope is that this study will contribute to the growing literature on this particular group of people. Additionally, the researcher hopes that this study will inspire others to conduct research that provides more insight about this historically under researched group and the contribution that they make as clinical psychologists.



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## 6 APPENDICES

### Appendix A - Extract from Reflective Journal

The following excerpt has been taken from the reflective journal that the researcher kept throughout the research process.

#### Thoughts after fifth interview

Following the fifth interview, I noticed that I am really enjoying interviewing people. It's a different role to being a therapist but I can't help but feel that there are some similarities. I'm definitely using engagement skills, trying to deconstruct with people, the meaning of their experiences. I think I was expecting participants to be upset when they talked about their past experiences but this hasn't been the case so far. The interview felt really comfortable, partly because the interviewee was so warm. She has lots of enthusiasm for her job and for her life, it's hard to imagine that she experienced problems in her family when growing up.

I also noticed that I am developing confidence in my interviewing technique. Due to this, I tried to focus on opening up novel areas or ideas within the interview as opposed to sticking to just the areas in the interview schedule. I've been trying this with various results in the last three interviews. In this interview it meant that we didn't talk about theoretical orientation as much as I would have liked. For me, this really highlights the tension between finding out novel ideas during the interview and being able to cover all aspects of the interview. One positive thing is that she did mention some things that I hadn't thought about before or remember seeing when doing my literature review. I wonder how much her account will show in the sample as a whole?

I'm still not sure what the final analysis will look like but I'm starting to feel that there are points of convergence and divergence within the data, hopefully some of these will be themes that emerge when I've interviewed all eight participants.

## **Appendix B- Example of One of the Recruitment Emails Sent to Participants**

From: Olumayowa AINA [<mailto:u1234968@uel.ac.uk>]

Sent: 30 August 2014 10:48

To: [REDACTED]

[REDACTED]

Subject: Thesis request

Hello everyone,

I hope you're enjoying the summer.

I just wanted to forward some details about my thesis as I'm currently looking for participants, so please have a look at the attachment above.

If you happen to know of any qualified or trainee psychologists (Counselling, Clinical, e.t.c.) who have experienced psychological distress before they commenced professional training and who might be interested in taking part in my research, then please do forward them the attached.

Thank you,

Mayowa

## Appendix C – Email Correspondence Regarding Blog Advertisement

**From:** [REDACTED]  
**Sent:** 28 August 2014 10:01  
**To:** Olumayowa AINA  
**Cc:** [REDACTED]  
**Subject:** RE: Re: request for help with a research study

Hi Mayowa,

Great, I've just tweeted the details

[https://twitter.com/\[REDACTED\]/504916250720735232](https://twitter.com/[REDACTED]/504916250720735232)

I've also circulated the info to [REDACTED] trainees. Sounds a very useful study, good luck with it.

[REDACTED]

**From:** Olumayowa AINA [mailto:u1234968@uel.ac.uk]  
**Sent:** 28 August 2014 09:39  
**To:** [REDACTED]  
**Cc:** [REDACTED]  
**Subject:** RE: Re: request for help with a research study

Hi [REDACTED]

Thanks for your email.

Please find below a link to a blog page that I've set up for the study.

<http://u1234968.blogspot.co.uk/2014/08/has-experience-of-distress-influenced.html>

Kind regards,

Mayowa

---

----- Original Message -----

Subject: Re: request for help with a research study

From: "[REDACTED]" >

To: [REDACTED]

CC:

Hi [REDACTED]

Is this request online somewhere or could it be? Then I could tweet it.

[REDACTED]

## **Appendix D – Semi-Structured Interview Schedule**

This interview schedule is designed to be used flexibly with participants in order to provide the best opportunity for them to give free accounts of their experiences.

Introduction:

-

Introduce self and study

-

Emphasise consent, confidentiality, and process of interview

-

Check for participant queries

Demographics information -Note whether trainee or qualified

Also note as needed: course, year of study, age, gender, nationality, placements undertaken

Interview questions/ topics

-

Own definition of distress

-

Experience(s) of distress that are significant to participant

-

Experience(s) of distress influence on training as psychological therapist

-

Benefits of this experiential knowledge

-

Costs of this experiential knowledge

-

Perceived views of the profession regarding experiential knowledge

-

Preferred theoretical orientation

-

Views on relationship between experiential knowledge and preferred theoretical orientation

-

Experiential knowledge with regards to client work, placement, supervision and university

-

Sources of support regarding experiential knowledge

-

Positive and negative experiences of experiential knowledge as a trainee/qualified and outside of the profession

-

Views on using own knowledge when working professionally

End-Thank participant and check if any further questions.

## Appendix E – Participant Information Sheet



UNIVERSITY OF EAST LONDON

School of Psychology

Stratford Campus

Water Lane

London E15 4LZ

The Principal Investigator(s)

Olumayowa Aina

u1234968@uel.ac.uk

### Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my professional doctorate in clinical psychology degree at the University of East London.

### Project Title

How does experiential knowledge of distress influence the decision to train as a Psychological Therapist?

### Project Description

The aim of this project is to explore how experiences of distress influence the decision to apply for clinical training. I am inviting trainee and qualified clinical psychologists to talk about their experiential knowledge of distress and how it has

influenced their career so far. This will be achieved through individual interviews lasting about an hour.

At the end of the project, the interview transcripts will be analysed using a method called Interpretative Phenomenological Analysis. This is a method of looking at the meanings people make of their experiences. The project will be written up as a doctoral thesis at the University of East London and may be published in an academic journal.

You will be asked questions about the potential benefits and costs of your experiential knowledge and how this relates to your training and experiences at work.

### Confidentiality of the Data

Your name and contact details will be stored in a password-protected folder on the researcher's home computer. Consent forms will be stored in a locked cabinet in the researcher's home. E-mails will be sent from the researcher's UEL email account. Identifying references to participants will be removed from any material used in the write-up of the study. Audio recordings will be transcribed and the recordings deleted after the end of the study. Anonymised transcripts will be kept for further analysis.

Throughout the recruitment process, if you say something that makes the interviewer consider that there is a risk of harm to you or to others, it may be necessary to break confidentiality to tell other professionals in order to ensure your safety and/or the safety of others. Where possible the interviewer would always try to share this with you first.

### Location

Wherever possible interviews will occur at the UEL Stratford campus, however if you are unable to attend I am willing to discuss meeting with you at a more convenient location.

### Remuneration

There is no financial remuneration for taking part in this study.



## Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [Dr David Harper, Professional Doctorate in Clinical Psychology, School of Psychology, University of East London, Water Lane, London E15 4LZ. 020 8223 4021. [d.harper@uel.ac.uk](mailto:d.harper@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: [m.finn@uel.ac.uk](mailto:m.finn@uel.ac.uk))

Thank you in anticipation.

Yours sincerely,

Olumayowa Aina

Date:

## Appendix F – Participant Consent Form



### UNIVERSITY OF EAST LONDON

Consent to participate in a research study

How does experiential knowledge of distress influence the decision to train as a Psychological Therapist?

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

I give permission for the researcher to include anonymised quotes from the interview in the thesis produced and in any subsequent publications.

I am aware that throughout the recruitment process, if I say something that makes the interviewer consider that there is a risk of harm to me or to others, it may be necessary for the researcher to break confidentiality and to tell other professionals in order to ensure my safety and/or the safety of others. I understand that where possible the interviewer would always try to share this with me first.

I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

OLUMAYOWA AINA.....

Researcher's Signature

.....

Date: .....

## **APPENDIX G: Letter of Ethical Approval**

### **ETHICAL PRACTICE CHECKLIST (Professional Doctorates)**

**SUPERVISOR:** David Harper

**ASSESSOR:** Mark Holloway

**STUDENT:** Olumayowa Aina

**DATE (sent to assessor):** 28/07/2014

**Proposed research topic:** How does experiential knowledge of distress influence the decision to train as a Psychological Therapist?

**Course:** Professional Doctorate in Clinical Psychology

1. Will free and informed consent of participants be obtained? **YES / NO**
2. If there is any deception is it justified? **YES / NO / N/A**
3. Will information obtained remain confidential? **YES / NO**
4. Will participants be made aware of their right to withdraw at any time? **YES / NO**
5. Will participants be adequately debriefed? **YES / NO**
6. If this study involves observation does it respect participants' privacy? **YES / NO / NA**
7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? **YES / NO / NA**
8. Is procedure that might cause distress to participants ethical? **YES / NO / NA**

9. If there are inducements to take part in the project is this ethical? YES /  
NO / **NA**

10. If there are any other ethical issues involved, are they a problem? YES /  
NO / **NA**

APPROVED

YES	YES, PENDING MINOR CONDITIONS	NO
-----	----------------------------------	----

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: MH Date: 2/8/14

## RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

**SUPERVISOR:** David Harper

**ASSESSOR:** Mark Holloway

**STUDENT:** Olumayowa Aina

**DATE** (sent to assessor): 28/07/2014

**Proposed research topic:** How does experiential knowledge of distress influence the decision to train as a Psychological Therapist?

**Course:** Professional Doctorate in Clinical Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

1      Emotional                      YES / **NO**

2.      Physical                        YES / **NO**

3.      Other                            **YES** / NO  
(e.g. health & safety issues)

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as:                      HIGH / MED / **LOW**

APPROVED

YES	YES, PENDING MINOR CONDITIONS	NO
-----	----------------------------------	----

**MINOR CONDITIONS:** I would like to be assured that interviews will only take place in the homes of participants when all other options have been properly explored, including UEL, workplaces and neutral meeting places. There is no need to resubmit the ethics form so long as this request is observed by the researcher.

REASONS FOR NON APPROVAL:

Assessor initials: **MH** Date: 2/8/14

For the attention of the assessor: Please return the completed checklists by e-mail to [ethics.applications@uel.ac.uk](mailto:ethics.applications@uel.ac.uk) within 1 week.

## SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



### School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ  
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937  
e-mail: [mno.davies@uel.ac.uk](mailto:mno.davies@uel.ac.uk) web: [www.uel.ac.uk/psychology](http://www.uel.ac.uk/psychology)



The University of East London has campuses at London Docklands and Stratford  
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853





Emergent Themes

long process of integrity  
different selves

Context influences  
presented self

Behaviours as tools

Reaching an authentic  
self

Finding integrity  
through integrity self

Personal therapy  
as transformative

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## **Appendix I –Example of Superordinate Themes for One Participant**

### **Klaus – Superordinate Themes**

#### **Tolerating Distress**

Tolerating/containing distress 7.270-276 “I’m pretty calm”

Being alongside distressed people 7.280-287 “being alongside”

Resonating with vulnerability 6.207-213 “vulnerability touches me”

#### **Family and Mental Health**

Family values 4.112-119 “public service was what you did”

Following parent’s footsteps 4.119-121 “want to be an English teacher”

Influence of parent’s mental health problems 5.147-153 “no coincidence”

Inevitability of contact with mental health services 5.150-153 “one way or the other”

Distressing experiences due to mother’s mental health 5.154-169 “drag me into”

#### **Making Decisions**

Conscious decisions 4.127-130 “conscious level”

Altered life trajectory 4.123-129 “I flunk it”

Affinity for psychology 4.130-132 “shone at it”

Unconscious choices 5.142-149 “why was I interested?”

#### **Developing a Theoretical Orientation**

Theoretical orientation developing a shared language 8.313-317 “understanding a language”

Theoretical orientation as an indicator of being a clinical psychologist 8.299-307 “be a psychologist”

Theoretical orientation contains anxiety 8.318-327, 9.351-363 “very, very scary”

Pragmatic approach to Theoretical orientation 9.370-372 “the whatever works orientation”

Behaviours as tools 2.57-63 “behaviours that I use”

Mantles of truth 10.374-393 “wear that for periods of my professional life”

Becoming comfortable with uncertainty 10.401-411 “I’m starting to trust”

### Linking Personal and Professional

Taking responsibility links personal and professional 11.419-423 “being able to shed those mantles”

Integrating professional and personal self 12.500-509 “part and parcel”

Long process of integrating different selves 2.47-54 “process of a lot of work”

### Cathartic Experiences

Finding integrity through integrating self 2.69-75 “don’t have to be out of integrity”

Personal therapy as transformative 11.450-456 “work I needed to do”

Crisis as turning point 12.471-475 “a turning point for me”

### Disclosure Process

Disclosure as uncertain process 6.226-237 “got to be really careful about that”

Ego seeking reactions 7.243-248 “in ego territory”

### Experience of Self

Conflict with the core self 3.92-98 “deeper within not in that state”

Reaching an authentic self 2.60-68 “being comfortable”

Defending the self 3.100-109 “being far truer to myself”

Accepting sick self 11.431-438 “attend to that with love”

Taking responsibility for self 12.484-89 “my own responsibility”



## Appendix J –Example of Superordinate Themes for the Group



