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Qualified Counselling Psychologists' Perspectives and Experiences of Personal Therapy in the Context of Continuing Personal and Professional Development

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Qualified Counselling Psychologists' Perspectives and Experiences of Personal

Therapy in the Context of Continuing Personal and Professional Development

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Preface

My interest in this topic began during my training as a counselling psychologist, during which it was a course requirement to engage in personal therapy. This was my first experience of personal therapy as a client, and, just as I entered personal therapy as a client I also entered therapy for the first time as a trainee therapist. Through personal therapy I became more aware of certain aspects of myself, some of which I had not been prepared for, and would have preferred not to, explore. Many of the issues that my clients discussed in my clinical practice mirrored difficulties I had previously encountered or was experiencing at that time. This helped me to fully recognise and appreciate the fundamental importance of therapist self-reflection and self-awareness, to ensure that my own personal issues would not negatively impact my clinical practice and damage the therapeutic alliance I was trying to build with my clients. Personal therapy further acted as a self-care activity, a place where I could develop self-awareness and identify and work on my difficulties and blind-spots.

As I approached the end of my training, I became interested in what the role and purpose of continuing to engage in personal therapy would be, both for myself and for other qualified counselling psychologists. This led to the development of the research questions for the present study.

Abstract

In the UK, engagement in personal therapy (PT) is an integral requirement of professional training in counselling psychology. However, despite the importance of PT during training, there is no current requirement for practicing counselling psychologists to continue this post-qualification. The aims of this study were: to explore the reasons that counselling psychologists engage (or not) in PT post-qualification; to understand counselling psychologists' views of PT as contributing to their professional and personal development; and to explore counselling psychologists' views of PT as a potential CPD activity.

Using Charmaz's (2006) constructivist grounded theory approach to analyse the data, five major categories were constructed through the analysis: personal growth versus personal crisis; practice what you preach; the ideal therapist; compliance and confusion of compulsory PT as trainees; and approval, ambivalence and constraints of PT as post-qualification CPD. The core constructed theoretical category - *diverging attitudes towards the role of post-qualification personal therapy* - was considered to represent qualified counselling psychologists' uncertainty about the role of PT therapy in the context of their own ongoing personal and professional development.

Most participants described seeking therapy post-qualification for self-reflection and for emotional support in a time of crisis. Many were in favour of PT as a voluntary CPD activity to be engaged in sporadically for short periods over one's professional career. However, participants were less in favour of PT as a compulsory CPD activity. The findings are discussed with regards to the relevant literature and the implications they have for the discipline of counselling psychology, for training and for the continuing professional development of counselling psychologists. The findings draw attention to the counselling psychologists' voluntary engagement with PT post-

qualification, and has helped to elucidate how PT is understood, viewed and engaged in, or not, by qualified counselling psychologists as an activity for CPD.

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1. INTRODUCTION

This study investigates the role, if any, of personal therapy (PT) in the continuing personal and professional development of the qualified counselling psychologist. In particular, the study sought to explore: qualified counselling psychologists' views and experiences of PT; whether they felt that therapy had contributed to their personal and professional development; and their views of PT in the context of requirements for continuing professional development (CPD).

Chapter 2 outlines the relevant literature, focusing on studies that have explored the topic of PT for the trainee and qualified therapist. A definition of PT is provided, followed by a brief history of the concept of PT for the therapist and current requirements for PT across different therapeutic orientations and training programmes. This is followed by a review of studies that have previously investigated PT for therapists, and a summary of the literature specifically relating to PT and counselling psychology. Finally, the aims and main research questions of the present study are outlined.

Chapter 3 describes the methodological approach for this study. The research paradigm and epistemological position of the study are described, which justified the selection of a qualitative research methodology. The onto-epistemological basis for Charmaz's (2006) GT method is outlined, alongside a consideration of alternative approaches and the reasons why they were rejected. The method is outlined in Chapter 4, which describes the process of recruiting participants and the data collection and analysis methods. This chapter also contains a reflective element, on the role of the researcher in the research process and the ethical considerations that were taken into account when designing and conducting the study.

The analysis and findings are presented in Chapter 5, which summarises the emerging themes from the interviews, including illustrative segments of participants'

accounts of their views, experiences, and understanding of PT for qualified counselling psychologists. The final construction of a theory, representing an explication of a process derived from the researcher's interpretation and the accounts provided by participants, is presented.

Finally, the findings are discussed and related to existing literature (Chapter 6), to ground the findings in a concrete way and to further our understanding of PT for the qualified counselling psychologist. The implications of the findings to the practice and professional discipline of counselling psychology are discussed, as well as the limitations of the study and suggestions for further research. The present paper ends with a critique of the study and a reflexive summary of the researcher's experience of performing the research.

2. LITERATURE REVIEW

This chapter starts by defining 'personal therapy' (PT) and other key terms used throughout the study, and outlines the current requirements for counselling psychologists and therapists in other training programmes to engage in personal therapy as part of their training and ongoing continual professional development post-qualification (CPD). This is followed by a review of the available literature and empirical research on PT in the context of the personal and professional development of therapists across a range of psychotherapeutic orientations and professional qualifications. The literature is grouped by four broad themes: (i) the perceived benefits of PT for therapists; (ii) unhelpful aspects of personal therapy for therapists; (iii) therapists' reasons for engaging (or not) in personal therapy, and; (iv) the role of the therapists' therapeutic orientation in their engagement with personal therapy. The literature that specifically relates to PT for counselling psychologists is also examined, and the present research is situated within this existing body of work on therapists' PT. Finally, the aims and main research questions of the present study are outlined.

2.1 Defining Personal Therapy, Therapists, and Psychologists

The British Psychological Society (BPS) provides a broad definition of psychological therapy as "the practice of alleviating psychological distress through discussion, between client and therapist…often referred to as talking therapy" (BPS, 2015). 'Personal therapy' is often used interchangeably with 'psychological therapy', 'psychotherapy' or 'counselling', and can be used to refer to a broad range of therapeutic orientations which are based upon different theoretical models and utilise a wide variety of intervention styles and techniques.

Personal therapy takes place between the client(s) and a therapist, who will be trained in a particular (or several) theoretical orientation including cognitive-

behavioural (i.e., cognitive-behavioural therapy, rational emotive therapy, dialectical behaviour therapy), psychodynamic, psychoanalytic, humanistic person-centred; existential and gestalt therapies. Each orientation is based upon models, theories and assumptions that determine the process of therapy. Therapies also have different modes of application - individual, couple, family, or group (Woolfe, Strawbridge, Douglas and Dryden, 2010).

Because of the wide variety in approaches and modalities, in the present study the term 'personal therapy' is used to refer to individual therapy of any theoretical orientation. Where possible, PT engaged in *during training*, and PT engaged in *post-qualification* is also differentiated within the text, to make clear the difference between (for counselling psychologists) PT that is a mandatory training requirement, and PT post-qualification that is currently optional.

In many of the studies reported in the literature review, the term 'therapist' is used when describing participants and samples. Therapists can be trained in and use a range of therapeutic orientations as outlined above. Although counselling psychologists do practice 'therapy' and may specialise in any of the therapeutic orientations during their career, the present paper will distinguish between *counselling psychologists* who have undergone formal training in counselling psychology and are chartered by the BPS, and *therapists* who will have trained in other modalities and therapeutic approaches but are not counselling psychologists.

2.2   History of Personal Therapy for the Therapist and Trainee Therapist

For therapists to develop competence in the forms of PT they practise with clients, they must undertake training, usually of several years. For most professional training qualifications, being in PT is a requirement.

Wilkins (1997) advocates PT for the therapist as a way to develop professionally. He suggests therapists utilise PT to address unresolved difficulties and to

identify any potential ingrained attitudes and prejudices held, so that these do not impact on the work with clients. Wilkins also views PT as experiential learning for the therapist receiving the therapy. It provides an opportunity to observe and learn from their own therapists' responses and the techniques implemented, and enables them to take the perspective of a client and develop an understanding of their own clients' experiences of therapy with them.

There is a long history of discussion about the role and importance of PT for both trainee and qualified therapists within the different theoretical approaches (Daw, & Joseph, 2007; Donati & Watts, 2005; Grimmer & Tribe, 2001; Guy & Liaboe, 1986; Kumari, 2011; Liaboe, Guy, Wong & Deahnert, 1989; Macaskill, 1988; Macaskill & Macaskill, 1992; Macran & Shapiro, 1998; Macran, Stiles & Smith, 1999; Orlinsky, Schofield, Schroder & Kazantzis, 2011).

When asked about the person who wished to become an analyst, Freud replied "The answer is in the analysis of himself, with which his preparation for his future activity begins" (1937, p.248). So, with the birth of psychoanalysis, the view of the therapist's own PT as being a desirable, even necessary, requirement for training was introduced and the psychoanalytic tradition has always placed great emphasis on PT for trainees. It views PT as a way to work on unconscious drives or motivations, and for identifying and working with the transference and countertransference that arises within therapy (Kumari, 2011; Lemma, 2013). Freud also advised analysts to undertake psychoanalysis approximately every five years after completing their training. The rationale for this recommendation is that therapists can only be of any use to their clients through their own self-awareness and self-reflection. As Jung stated, "only if the doctor knows how to cope with himself and his own problems will he be able to teach the patient to do the same" (1966 p.132).

The present requirements of the British Psychoanalytic Association (BPA) and the Institute of Psychoanalysis (IoP) are that trainees engage in analysis with a qualified psychoanalyst for at least one year before commencing their training, and continue at least four or five times a week throughout training (Institute of Psychoanalysis, n.d.) The UKCP includes 80 member organisations all of which have extensive PT training requirements, one exception being the members of the behavioural and cognitive psychology section (Rizq, 2010). The United Kingdom Council for Psychotherapy (UKCP) requires trainees to undergo 40 hours of PT per year over four years training, usually within the same therapeutic modality in which they are training (UKCP, 2011). Since 2002, the British Association for Counselling and Psychotherapy (BACP) has removed the requirement of mandatory PT for trainees, as it was questioned whether insisting on PT was beneficial or posed more risks (Atkins, 2006). The British Association for Behavioural and Cognitive Psychotherapists (BABCP, 2012) current minimum training standard for the practice of counselling and psychotherapy states that therapists must have ensured that they can identify and manage their personal involvement in the process of cognitive and/or behavioural therapy appropriately, and must have developed an ability to recognise when they should seek additional professional advice and supervision. No mention of PT is made as a part of personal development.

Post-training, qualified psychoanalytical psychotherapists undertake at some point in their professional career psychoanalysis at least four or five times a week with a qualified psychoanalyst, with no specification made regards the length of time. Existential and humanistic approaches also emphasise the importance of trainee therapists developing the basic qualities of self-acceptance, genuineness and congruence (Mearns & Thorne, 2007; Rogers, 1961, 1966). The UKCP outlines that qualified professionals are required to undertake a range of CPD activities including clinical

supervision, research, workshops and which show evidence of reflexive and reflective practice (UKCP, 2015). Engagement in PT is specified as a "non-mandatory" element of CPD. With regards to the BACP once qualified, there is no mandatory specification for PT as a CPD activity.

Existential and humanistic approaches also emphasise the importance of trainee therapists developing the basic qualities of self-acceptance, genuineness and congruence (Mearns & Thorne, 2007; Rogers, 1961, 1966). The role and importance of engaging in PT for cognitive-behavioural therapists (CBT) has shifted over the past 50 years, in line with the evolution and development of cognitive-behavioural approaches. Initially, PT was not considered relevant during CBT training or following qualification because 'second wave' CBT did not focus on unconscious processes but on conscious thought. Consequently, issues of transference and countertransference were not considered relevant to the practice of CBT or likely to interfere with the client's experience or outcomes of CBT. There has been a progressive change in this view as CBT has developed to incorporate an increased emphasis on working with interpersonal factors in the therapeutic relationship (Gilbert & Leahy, 2007; Laireiter & Willutzki, 2005; Leahy, 2008). At present, the requirements set out by the BABCP are that in order to obtain a qualification in cognitive behavioural psychotherapy there is no requirement to undertake PT, with no mention of this as part of training or post-training (BABCP, 2012).

The eminent existential psychotherapist Irvin Yalom (2003) stressed the importance of self-reflective practice and PT for the practicing, qualified therapist. His position is that the most valuable instrument to the therapist is his or her own self, and he suggested that self-exploration is a process to be continued throughout the therapists' life. Yalom has also recommend that therapy be "as deep and prolonged as possible and that the therapist enter therapy at various stages of life" (2003, p.40). Yalom (2011) also

suggests that therapists engage in diverse forms of therapeutic approaches therapy depending on the presenting problem and goal of therapy. By way of illustration, Yalom noted that whilst working with dying patients he was struck by death anxiety and consequently sought help from an existential psychotherapist, and yet when needing to deal with his insomnia he turned to a behavioural therapist.

An important distinction is made by Mearns (1994) regarding the role of PT for the therapist. Mearns states that the effectiveness of a therapist is not about whether they have addressed all of their own personal struggles, but that they have the ability to be aware of, and minimise any effect that these struggles may have on their practice. Indeed, Jacobs (1988) suggests that it is not necessary to seek to be a "perfect" therapist, but to aim to be a "good enough" therapist, given one's own personal difficulties and weaknesses (Jacobs, 1988).

2.3 Current Requirements for Personal Therapy in the Training and Continuing Professional Development of Counselling Psychologists

The discipline and profession of counselling psychology is a comparatively new form of applied psychology that aims to integrate psychological theory and research with therapeutic practice (BPS, 2006). Counselling psychology in the UK is strongly influenced by the psychotherapeutic traditions and also by human science research, and is differentiated from other psychological disciplines (e.g., forensic psychology, clinical psychology, occupational psychology, health psychology), as it places itself between the formal scientific method and humanistic psychotherapy (Corrie & Callahan, 2000). Specifically, whilst an emphasis is placed on the importance of an empirical basis for research and practice, counselling psychology simultaneously places value on the importance of the therapeutic relationship and the therapists' understanding of relational dynamics in practice (Strawbridge & Woolfe, 2010).

The profession of counselling psychology has developed to include different therapeutic approaches including humanistic/ existential, psychodynamic/ psychoanalytic, and cognitive- behavioural (Strawbridge & Woolfe, 2010). Trainees undergoing counselling psychology training will generally be exposed to all three approaches, both in theory and in practice**.** Consequently, one of the characteristic features of counselling psychology training is the requirement of PT, which other BPS divisions such as clinical psychology or forensic psychology do not have. This requirement stems from the fact that the interpersonal skills of the therapist and their understanding of the interaction of subjective and intersubjective dynamics in the therapeutic relationship are considered to be of great importance in the applied work of counselling psychologists (Woolfe, 1996).

The training of counselling psychologists in the UK is overseen by the British Psychological Society (BPS), with various UK universities delivering the training and monitoring trainee counselling psychologists' development as practitioners. Amongst a range of requirements to demonstrate and develop competence and knowledge for practice, the current BPS requirement for PT within the counselling psychology training pathway is that trainees undertake a minimum of 40 hours of PT during a programme of study that can take between three to four years full-time, although some universities require a lengthier engagement with PT (Moller, Alilovic & Mundra, 2008; Rizq & Target, 2008).

Once a trainee has qualified they are required to register as a counselling psychologist under the Health and Care Professions Council (HCPC, 2012). The HCPC is an independent regulatory organisation that establishes the standards of practice and competence for members of various professions, including practitioner psychologists. The HCPC keeps a register of health and care professionals who meet their standards of training and professional skills, and sets standards for CPD. Professional members are

required to engage and keep records of their CPD activities, auditing a sample of members each year (HCPC, 2012). The CPD activities listed by the HCPC are contained within five categories: work based learning, professional activity, formal and educational, self-directed learning, and 'other' (HCPC, 2012). These include a variety of learning activities that encourage health professionals to continue to learn and expand their skills throughout their career, ensuring that they are continually able to practice in a safe, ethical, legal and effective manner. There is currently no specific reference within the CPD categories outlined by the HCPC to PT as an optional or required activity for practitioner psychologists of any discipline.

2.4   How Personal Therapy Supports the Training of Counselling Psychologists

For counselling psychologists, being self-reflective and possessing an understanding of interpersonal dynamics that unfold and impact on the therapeutic setting are seen as important skills and abilities (Strawbridge & Woolfe, 2010). This is because the counselling psychologist is not viewed as an emotionally disengaged 'expert' who implements techniques from an external perspective, but is regarded as being actively engaged in the therapeutic relationship with the client and participating in the process of co-creating meaning about their subjective experiences (Hedges, 2010; Strawbridge & Woolfe, 2010).

Counselling psychologists that are in training are encouraged to engage in self-reflective practices that are focused on facilitating their growth and self-awareness, such as focus groups, peer supervision, and reflective journal writing (Rizq, 2006). Personal therapy plays a significant part in the counselling psychologists' training, because it creates an opportunity to explore and strengthen any personal struggles, vulnerabilities and blind spots which, if unaddressed, may surface in the work with clients and hinder the process of therapy. This process further contributes to making their practice safer,

reducing the risk of harmful outcomes (Strawbridge & Woolfe, 2010; Woolfe, Strawbridge, Douglas, & Dryden, 2010).

Therefore, PT is considered to offer trainee counselling psychologists a space to develop their personal and professional capabilities, to develop and enhance self-reflective practice and self-awareness and the dynamics present in the therapeutic relationship. As Rizq (2010) identifies, there is an "emphasis on self-awareness in training and on the use of the self of the therapist in clinical work underpins the current place of personal development work in the training of counselling psychologists" (p. 570). This is because counselling psychology practice requires "a high level of self-awareness and competence in relating skills and knowledge of personal and interpersonal dynamics in the therapeutic context" (BPS, 2009). Given this, it might be assumed that PT would continue to be as important in the ongoing maintenance and development of personal and therapeutic skills and to maintain safe, competent and ethical practice for qualified counselling psychologists. However, PT post-qualification is currently not endorsed or monitored by the BPS or HCPC.

2.4.1 The person of the therapist

One important factor that is viewed as contributing to therapeutic outcomes – regardless of therapeutic orientation – is "the person of the therapist" (McConnaughy, 1987). This relates to who the therapist is as a person and how their "personal development, interpersonal style, and life experiences…shape the emotional climate, theoretical perspective, and techniques" that they offer their clients (McConnaughy, 1987, p.303). Although the personal qualities of the therapist can help or hinder therapy, qualities help the client trust the therapist and the therapeutic process and feel safe in the therapeutic relationship are frequently reported as being a significant non-specific factor that contributes to effective therapy (Norcross, 2002; Wampold, 2001; (Daw & Joseph, 2007; Gilbert & Leahy, 2007; Norcross, 2005; Wampold, 2001) A substantial body of

psychotherapy literature and research attests to the importance of the therapist's personal contribution as a key common factor that influences the quality and outcomes of therapy (Jacobs, 2011; Orlinsky, Norcross, Ronnestad & Wiseman, 2005; Wiseman & Shefler, 2001). Another common factor that is associated with therapeutic outcomes is the strength of the therapeutic relationship, or working alliance between the client and the therapist (Gold, Hilsenroth, Kuutmann & Owen, 2014; Martin, Garske, & Davis, 2000; Muran & Barber, 2010).

In line with the common factors research on the person of the therapist, Bloomfield (1989) has stated that what is most important in therapy is "how we are as therapists with our patients, rather than what we do or say" (p. 49). For this reason, she suggests that it is vital that therapists continue to work on themselves, facing and uncovering aspects that may be defended against and kept hidden.

The person of the therapist is discussed by Aponte and colleagues (2009) and by Aponte and Winter (2000), who propose the person-of-the-therapist training model. This model was originally developed to train postgraduate therapists and focuses on the importance of the person of the therapist and of self-exploration (Aponte & Winter, 2000). The philosophy behind this model is that each individual is unique, with his or her own unique life experiences, gender, family histories, culture, ethnicity and many more unique attributes that have shaped who they are. Intertwined with these life experiences are the disappointments, loss and hurt that one is subject to through life, which are considered as imprinting themselves onto the persons emotions and attitudes in their personal and professional lives. Being a therapist requires dealing with people's wounds, which can be empathised with and understood at an intuitive depth, due to the therapists struggle with their own wounds and personal vulnerabilities (Aponte et al., 2009). This model considers it important that therapists attend to their difficulties, so

that they can continue to work in an effective and professional manner, minimising harm to clients and to themselves.

Lum (2002) states that "the development of the therapist is a significant aspect of becoming an effective therapist" (p. 181) with this view supported by other authors have also recognised the self of the therapist as an important contributor to developing a therapeutic relationship (Aponte & Winter, 2000; Baldwin, 2000; Mearns & Thorne, 2007). The use of self is considered to be more than the therapist sharing a similar experience of self with clients, but it's about being in touch with the present moment, monitoring oneself and the client.

Supervision can facilitate self-reflection on a practitioner's clinical work to ensure that they continue to work in a professional, safe, and ethical manner with their clients. However, PT allows for more self-exploration and understanding of one's own internal processes and how these play out in one's life and in interactions with others. Whilst these two overlap, PT is understood to promote personal development and supervision professional development, but this not always the case and not always very clear.

However, the 'person of the therapist' as being an ingredient of therapy and of therapeutic change is argued to be very much linked to the therapist's therapeutic orientation (Reupert, 2006, 2008). For instance, a therapist practicing from a psychodynamic point of view will consider transference and countertransference to be an important part of therapy, whereas a cognitive therapist may consider these phenomena to be a less important aspect of successful therapeutic treatment, instead focusing on changing unhelpful thought patterns. Depending on the emphasis the therapeutic modality places upon the importance of the interpersonal dynamics between the patient and the therapist and, consequently, the view of the 'person of the therapist' as contributing to the therapeutic process, it might be argued that personal development

and self-awareness cannot easily be separated from professional development and safe ethical practice. For instance, therapists (including counselling psychologists) practicing from a psychodynamic approach use the transference and countertransference to guide therapy, with a greater focus on the interpersonal dynamics and how these shape the therapeutic relationship and reflect the relationships in the client's life. This requires an increased sensitivity from the therapist to monitor each moment of therapy as it unfolds within themselves, from the patient's perspective and the interplay of dynamics between them. Conversely therapists practicing from a cognitive and behavioural approach will use structured techniques as a guide for therapeutic treatment, with less emphasis on the 'person of the therapist' as an intricate part of the therapeutic process. Thus, depending on the therapeutic orientation, PT might be a more important activity for continual self–awareness and personal development, contributing also to a therapist's or psychologist's professional practice and development, compared, say, to attending a seminar or a workshop.

Hermans and DiMaggio (2004) propose the notion of a "dialogical self", which refers to the self as being a multiplicity of parts arising from the interaction with society. They argue that there is an internal self, within the mind of the individual, but also an external self that forms in relation to others in society and through communication. They move the idea of the self as a self-contained entity to the self as being part of society. The person is part of society and creates meanings and knowledge through interactions and communications with others. The question of one or multiple selves is perhaps less important, but what may be more central is for the therapist to present an integrated self, without aspects of the self, split-off through suppression, repression or denial (McLeod & McLeod, 2014; Wilkins, 1997; Woolfe, 1996).

Understanding and developing the person of the therapist – through a therapist's own work on their self – is viewed as a life-long process that continues throughout their

professional life, and is never completed (Donati & Watts, 2005; Jacobs, 2011; Yalom, 2003). For counselling psychologists, this work is likely to be done in a number of ways. During training, personal development does not occur only through PT but also through experiential groups, reflective journal writing and supervision. Post-qualification, counselling psychologists might choose to engage in PT but are not required to. There are a broad range of activities that counselling psychologists can engage in for self-development including, courses, teaching, conferences, peer discussion (Martin, 2010). The function of engaging in CPD activities are to contribute to the continual effectiveness of the practitioner, to ensure practitioners are up-to-date with their skills and developments within their field, and is a contribution to life-long learning (Khele, 2007).

As Hart and Kogan (2003) propose "it is through continual reflection on who we are and how we work, as well as the therapeutic process, that we learn to be effective counselling psychologists" (p.24).

2.5 Personal Therapy Contributing to the Personal and Professional Development of Therapists

Personal therapy is generally understood to enhance both the personal and professional development of the therapist (Orlinsky, Schofield, Schroder & Kazantzis, 2011). Many research studies have confirmed that PT contributes to personal development through increased self-awareness, ability to deal with personal difficulties more constructively, and the general well-being of the therapist (Mahoney, 1997; Stevanovic & Rupert, 2004; Wiseman & Shefler, 2001). With regards to professional development, some studies have reported PT to contribute to developing reflexivity and acting as a model for professional learning (Williams, Coyle & Lyons, 1999; Grimmer & Tribe, 2001).

The notion of 'personal development' and 'professional development' in the fields of generic counselling and psychotherapy do not appear to be clearly distinct, and there is a lack of clarity of what personal and professional development mean (Donati & Watts, 2005; Williams & Irving, 1996). One explanation for this could be because professional therapists (of any therapeutic orientation) typically consider their own person to be part of the therapeutic relationship and therefore personal development *is* professional development (Donati & Watts, 2005; McLeod, 2003). A further possible reason for the ambiguity between personal and professional development is that these are inextricably linked, as both areas encompass a wide range of activities (Elton-Wilson, 1994; McLeod & McLeod, 2014). McLeod and McLeod (2014) propose a continuum from personal to professional development, with personal development being activities that focus primarily on how one relates to others, and professional development being predominantly concerned with activities that build knowledge and skills relevant to one's work. Wilkins (1997) provided a definition of professional development as being centred on skills and knowledge that are acquired through formal training, reflection and discovery. He defines personal development as consisting of reflecting on and dealing with personal issues and resistances, which increases one's capacity for interpersonal engagement.

Various activities are considered to contribute to enhance personal development, including reflective journal writing, personal development groups and seminars, co-counselling, reading, and life experiences (Rizq, 2010). However, as outlined previously, many therapeutic schools view PT as an effective and necessary means of personal development, both pre and post-qualification, but the routes to personal growth vary between the different theoretical orientations and between individuals too (Strawbridge & Woolfe, 2010; Rizq, 2010)

With respect to professional development, it might be argued that engaging in PT is not essential if the therapist is attending regular supervision. Clinical supervision is an important activity for the therapist and counselling psychologist. It fosters reflective practice and emphasises the importance of learning through experience, and is considered to be a self-care activity for therapists carrying out an emotionally challenging role (Lane & Corrie, 2006; Woolfe & Tholstrup, 2010). Unlike PT, supervision is a mandatory requirement for all qualified counselling psychologists throughout their professional lives (BPS, 2006).

Although PT and supervision are both self-reflective activities that enhance the development of the therapist, there are important differences between them. In supervision, the focus is on exploring one's clinical work and reactions to one's clients and the material they bring to therapy. Davy (2002) identifies supervision as a contested space in which the goal of ensuring the client's best interests and well-being remain a primary concern, which might clash with the supervisees' own personal development. Wosket (1999) considers supervision as helping the supervisee develop an awareness of their own personal reactions to clients and a forum in which the supervisee's responses to clients can be reflected upon and shaped into clinical strategies to guide therapeutic treatment. Personal therapy, on the other hand, allows for the exploration of oneself and the topic of investigation can be varied and not limited to a specific issue or individual (Woolfe & Tholstrup, 2010).

Supervision can take many forms- one-to-one, group, facilitated group; and peer supervision (BPS, 2007), and the choice of supervisor may be made by the therapist, or selected by an organisation they work within. Depending of the style and model of supervision, it might include, to various degrees, attention to the personal issues of the therapist and how they influence his or her practice. Thus, it might be the case that supervision will include elements of PT (Ekstein & Wallerstein, 1972; McNeill &

Worthen, 1989). For individuals working in independent practice, one-to-one supervision is most common and the choice of supervisor left to the supervisee. This could potentially allow the supervisee to feel more at ease with the selected supervisor because not part of their workplace, therefore enabling the supervisee to express themselves more openly and honestly. Further, private clinical supervision could perhaps make the need for PT less, because supervision might be more focussed on personal issues. However, for those working as part of an organisation, supervision is most likely to be selected for them. For instance, within the National Health Service (NHS), the choice of supervisor and supervision format is often restricted and determined by the organisation. In this situation, there may be a greater likelihood of experiencing difficulties in establishing a good working alliance with one's supervisor, which can hinder the professional development and learning process for the supervisee (Scaife, 2009; Woolfe & Tholstrup, 2010).

According to Scaife (2009), despite some of the similarities and potential for overlap between supervision and PT in terms of what is explored and learned within each relationship, the emphasis of supervision should ultimately be on education, rather than on therapy and personal self-exploration. However, for experienced therapists and counselling psychologists supervision may be used very differently to trainees. Whilst supervision for trainees may be more about gaining techniques and strategies for clinical practice, the use of supervision for the more experienced therapist may include exploration of interpersonal dynamics in the therapeutic relationship and assimilating knowledge of research and conferences and place these into practice (Page & Wosket, 2001).

To understand how counselling psychologists might benefit from therapy post-qualification and how PT might address important personal or professional development

issues that are not met by supervision alone, the literature on therapists' use and experience of PT was examined.

2.6   Extant Literature on Personal Therapy for the Therapist

A search of the academic literature was conducted to identify relevant studies that related to therapists' use of their own therapy. Three online databases, PsychARTICLES, PsychINFO and EThOS were used to identify full-text articles published between 1990 and 2015, using a range of keywords and search strings including: PT, psychotherapy, therapy for the therapist, PT for counselling psychologist and personal and continuing professional development. Over 700 studies were located that included PT and CPD for therapists and counselling psychologists as well as related professionals such as clinical psychologists, psychotherapists and counsellors. A more detailed search specifically entering the words therapy and counselling psychologists, and using references from key papers to identify relevant studies, returned fewer than ten studies. Of these, only three were related to the PT of counselling psychologists in the UK (Grimmer & Tribe, 2001; Rizq & Target, 2008; Williams, Coyle & Lyons, 1999).

The following sections present and discuss the key literature that was identified by the above search. First, the role and experience of therapy for therapists more generally are presented according to four main categories: The perceived benefits of therapy for therapists; the unhelpful aspects of personal therapy; therapists' reasons for engaging, or not, in therapy; and the role of the therapists' therapeutic orientation in their engagement with therapy. This is followed by the studies that relate specifically to PT for counselling psychologists in the UK.

2.6.1   The perceived benefits of personal therapy for therapists

Studies investigating therapists' experiences of therapy have found positive and negative impacts of PT. Benefits of therapy include fostering increased self-awareness and self-reflection, and that therapy provides a valuable source of experiential and practical learning about the role of the client, which in turn leads to increased empathy and patience for the client, and improved relational skills (Daw & Joseph, 2007; Norcross, 2005; Rake & Paley, 2009; Orlinsky, Norcross, Ronnestad & Wiseman, 2005; Rizq & Target, 2008; 2010). When Macaskill and Macaskill (1992) surveyed 25 trainee psychotherapists in the UK about their experiences of therapy, 87% reported therapy as having a moderate to very positive impact on both their personal lives and work with clients. Among the positive outcomes reported were increased self-awareness (76%) and reduction in their presenting symptoms (43%). Personal therapy is also viewed by therapists as contributing to a heightened understanding of the importance of the therapeutic relationship, and improving the therapist's ability to identify and work with transference and countertransference (Norcross, Strausser-Kirtland & Missar, 1988; Macaskill & Macaskilll, 1992)

Based on a longitudinal study spanning 15 years which focused on the personal and professional development of psychotherapists, Orlinsky, Botermans and Ronnestad (2001) collected data from 4000 psychologists from different countries, at different career levels and from a range of theoretical orientations. A quantitative study, using the Development of Psychotherapist Common Core Questionnaire and other questions to gather data, was carried out to investigate therapists' experiences and attitudes about their therapy. Questions asked related to therapists current theoretical approach, professional development, the positive or negative influences of therapy and supervision on self and the clinical work, current difficulties in therapy, theoretical orientation and approach to patients, coping methods for stress, emotional well-being. The majority of

therapists reported in this study were psychodynamic/psychoanalytic (58%), followed by humanistic (31%), cognitive (24%), systemic (21%) and behavioural (14%). The study found that 85% of participants described PT as a positive experience that was personally beneficial. Participants reported that having direct experience with patients and therapy as being among the most significant aspects on their career development. They expressed PT as enabling them to discover and work on their blind-spots and to develop an increased awareness of their impact on the therapeutic relationship and treatment.

The strengths of this study are that it was very inclusive, including psychologists from different countries, having trained in a wide range of theoretical orientations and asked many questions around PT and personal and professional development. However, a limitation could be that as participants were psychologists from different countries, it is difficult to make direct comparisons with counselling psychologists in the UK who hold a different training and CPD requirements. A further point to consider about this research is that the majority of the participants identified as adhering to the psychodynamic approach (58%), who generally are required to undergo many hours of therapy/personal analysis during and after training and therefore may have a more positive view or biased view of therapy. Perhaps having a more heterogeneous sample including other theoretical approaches (e.g., humanistic, cognitive, behavioural etc.) may have yielded different results. Further, a sample of only counselling psychologists who generally train in two or more therapeutic modalities may also generate even more diverse findings than therapists who train in perhaps only one theoretical approach.

Wiseman and Shefler (2001) conducted in-depth qualitative interviews with five experienced Israeli psychoanalytic therapists (two male, three female) to explore their experiences of therapy and its impact on their personal and professional development. The participants had all received their professional training in Israel, had at least 13

years of clinical experience, and had been in long-term therapy post-qualification. Narrative analysis was used to analyse the qualitative accounts, resulting in six themes: the importance of PT for therapists; the impact of therapy on professional identity; experiences in previous and current therapy; self in relation to the therapist; and mutual and unique influences of informative learning. The authors reported that the psychoanalysts interviewed considered therapy to have been essential during their training, but also important in their on-going process of individuation and the development of their ability to use the self to achieve authentic relatedness with clients.

This study offers a unique insight into the role of therapy during training and on-going process of development of the psychotherapist, and considers therapy as facilitating personal and professional growth and enhancing the ability to use of the self in the interactions with patients. However, the results should be considered in the context of the participant's training, practice and cultural context. Specifically, all participants in the study were psychoanalytically orientated. Training as a psychoanalyst (whether Freudian, Jungian, Adlerian etc.), is markedly different to the training undertaken by counselling psychologists. In fact, in the UK it is common for trainee psychoanalysts to spend their first year of training almost exclusively focused on their own personal analysis, and this is likely to be the case globally. The Institute of Psychoanalysis (IoP) states that only after a minimum of one year of personal analysis is a student eligible to commence theoretical training (IoP, n.d.). Because of the importance placed upon personal analysis and self-development in the psychoanalytic approach, the participants in this study would also have had more reason and possibly requirement to remain in PT post-qualification. It might also be the case that, because of their therapeutic orientation and allegiance to it, participants in this study had a preconception and expectation for personal psychoanalysis to be beneficial, in line with the beliefs that would have led to select this profession.

The impact of PT on UK therapists' clinical practice was investigated in a qualitative study by Macran, Stiles and Smith (1999). They interviewed seven practicing therapists (two males and five females) who identified as white British and were aged between 38 and 60. The therapists represented different theoretical orientations - including; body and relationship orientated therapy; person centred therapy; psychodynamic therapy and integrative and had all been working as therapists between 3- 20 years. Interestingly, therapists disclosed engaging in therapy that was different from their theoretical approach. Those who described their theoretical orientation as body/relationship orientated had disclosed seeking a Reichian therapist, those of psychodynamic orientation had sought therapy with a psychodynamic therapist, so had the therapists of integrative and person-centred approaches. Participants were interviewed about their experiences of therapy and how they felt it had contributed to their clinical work. Three themes emerged from an interpretative phenomenological analysis (IPA; Smith, 1995) of the interview transcript. First, under the theme orienting to the therapist participants' experience of therapy enabled them to gain an increased awareness of the issues of power and boundaries within the therapeutic relationship, a better understanding of the significance of their impact on the therapeutic process, and learnt how to manage their own presence in the therapeutic setting. Secondly, under the theme orienting to the client through their own PT participants learned to develop trust, respect and patience for the client, which helped them to offer additional space and time for clients to unveil their difficulties. Finally, under the theme listening with the third ear, participants' perceived that their PT contributed to their ability to work at a deeper unconscious level with themselves and with their clients.

This study specifically focused on the impact of PT on professional practice for a UK sample of therapists, from different theoretical backgrounds and reveals the potential benefit for counselling psychologists to remain in therapy post-qualification in

terms of their continuing professional development. Moreover, the therapists in this study spoke about being able to work at a deeper unconscious level not only with their clients but with themselves, which helped them distinguish between emotions and sensations belonging to themselves and those belonging to their clients, enabling them to understand their clients more intuitively.

Overall, the authors concluded that helpful experiences in the participants' own therapy were viewed by the participants as having a positive impact on their clinical practice (Macran, Stiles & Smith, 1999). However, because these findings represent participants' self-reports they do provide any objective account of whether their clinical practice actually improved as a result of their therapy. The researchers acknowledge that the small sample of participants in the study may not necessarily be representative of therapists more widely, and thus different results could be obtained from a different sample. Another limitation of this study is that all therapists were self-selected and interested in providing their experiences of how therapy affected their practice. Consequently, therapists with more positive experiences of PT might have been more likely to self-select for the study, which would explaining a lack of negative experiences reported.

In another UK-based qualitative study, Rake and Paley (2009) examined the perceived impact of PT on therapists' professional development and therapeutic practice. Eight practicing therapists (two males and six females) were recruited from a NHS psychological service. Participants had at least two years' experience as a qualified therapist, but had a range of different professional titles and varied in their clinical experience and theoretical backgrounds, which included psychodynamic/psychoanalytic, gestalt, humanistic and systemic. Participants had engaged with more than one episode of PT post-qualification, with episodes ranging from six months to ten years. However, reasons for entering PT were not investigated.

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One of the researchers of the study worked at the same service, which may have influenced participants taking part in the research. An IPA analysis of the interviews revealed three master themes: 'I learnt how to do therapy', 'to know myself much better', and 'a very dissolving process'.

Participants reported PT as being an educational experience, through which they 'learnt how to do therapy' by modelling themselves on their therapist. The quality of the relationship with their therapist and the comments and interpretations made by them had a particularly beneficial outcome on participants, providing them with confidence as therapist and to recognise and work with similar issues with their clients. Personal therapy was further considered to contribute to increased self-awareness and the ability to identify and acknowledge difficulties and limitations from within, represented by the theme 'to know myself much better'. Participants described how the emotional impact of exploring their own difficulties in therapy enabled them to realise that strong emotions were tolerable. As a result, they felt better able to tolerate these feelings in themselves, but also to not be frightened of similar emotional reactions of their patients. Finally, the theme 'a very dissolving process' included participant's descriptions of some aspects of therapy as unhelpful and at times damaging. Several participants reported that aspects of the therapists' manner, communication style, and therapeutic stance were unhelpful. Some comments made by their therapists were described as having a profound and lasting negative emotional impact (Rake & Paley, 2009).

One of the benefits of this study is that it reported also unhelpful experiences of therapy, where other studies perhaps have failed to do so (Daw & Joseph, 2007; Macran, Stiles & Smith, 1999; Rizq & Target, 2008; Wiseman & Shefler, 2001). A further benefit is that participants provided rich in-depth descriptions and not simply a numerical rating of how PT influenced their practice. The study again points to the benefits of PT for the professional development of therapists, including counselling

psychologists post-qualification. That this study examined the perspectives of NHS therapists is also relevant to the practice of counselling psychology, and the present research. From the mid 1990's counselling psychology has become more established within the NHS and many jobs that were previously only open to clinical psychologists are also open to counselling psychologists (James & Bellamy, 2010). One consequence of this is that many counselling psychologists in the UK will go on to work in psychological services within the NHS once they are qualified (Strawbridge & Woolfe, 2010), and so understanding the benefit of PT for therapists and psychologists who work in the NHS (an often highly stressful environment with challenging clients) is important (James & Bellamy, 2010, cited in Woolfe et al., 2010).

However, as with all studies, interpretations of the data are limited by the particular context, and any conclusions derived from the findings of studies mentioned need to be held tentatively. The benefit of qualitative studies that explore the lived experience of a small sample is that they provide rich detailed descriptions and understandings of a phenomenon. However, this also presents a limitation because interpretations made from the data to therapists in general, counselling psychologists in particular, or working as a therapist outside the NHS, cannot be generalised. Further, the fact that all participants worked within the same organisation, as did one of the researchers, might have influenced what participants chose to disclose or not in the interviews.

The findings from the studies reported in this section with regards to the benefits of PT need to be considered relative to the participants' specific training, practice and unique context. Although the studies indicate many benefits of therapy for the therapist, care needs to be taken when generalising to a wider population. Firstly, many individuals invited to take part in research studies do not take part. It is possible that

therapists who have had more helpful experiences of therapy may have been more forthcoming to take part in the research.

Whilst several studies have focused on investigating and reporting the beneficial effects associated with engaging in therapy, few have explored the difficulties that some therapists have experienced during this process.

2.6.2   Unhelpful aspects of personal therapy for therapists

Despite the perceived benefits of PT for therapists some studies have found that therapists can experience their own therapy as a very unsettling process (Rake & Paley, 2009). Wheeler (1991) conducted a correlational study investigating members of the British Association of Student Counsellors therapeutic approach and the therapeutic alliance they achieved with their clients, as perceived by both clients and therapists. Data on the counsellors' experiences of their therapy were also obtained. Two questionnaires were administered to 25 participants, who were from diverse theoretical orientations, including psychodynamic, humanistic or a mixture of both. The first questionnaire was in two parts. The first part asks participants to rate their subjective responses to 42 statements on PT on a scale from 1 to 5; the second part asks general information about theoretical orientation of the therapist, training, qualifications, experience and supervision. The second questionnaire, California Psychotherapeutic Alliance Scale (CALPAS; Marmar, Gaston, Gallagher & Thompson, 1987), measured the therapeutic alliance between the client and therapist, which was completed by the 25 therapists as well as one client per therapist, to capture the clients' view of the quality of the alliance. A positive correlation was found between the client measure of therapeutic alliance and the therapist prediction, and no correlation between groups of therapists of different theoretical orientations. Personal therapy was seen to be negatively correlated with the therapist prediction of therapeutic alliance, suggesting that the more PT the therapist experienced, the more likely they would predict a negative alliance with their

clients. The analysis of data revealed a significant negative correlation between the amount of PT counsellors had experienced, and the perceived quality of their therapeutic alliance with their clients. That is, the more a therapist had engaged in therapy, the more likely they were to also perceive a weaker therapeutic alliance with their clients.

One alternative explanation advanced by Wheeler to account for the negative correlation between PT and therapist ratings of the therapeutic alliance, is that engagement with PT gives the therapist more confidence in allowing the expression of negative transference and being able to tolerate it and work with it in the therapeutic setting. Indeed, perhaps the therapist who has engaged in therapy may be more able to recognise and accept when a therapeutic alliance is weak or ruptured − because they have experientially learnt about the client's perspective through their own therapy, and may have experienced ruptures that have subsequently been repaired or moved the therapy along within the therapeutic relationship with their own therapist. They might also be more confident to evaluate themselves critically, to have self-esteem and ego to not feel inadequate about not being the "perfect" therapist, but rather being a "good enough" therapist, given their own personal difficulties and weaknesses (Jacobs, 1988).

Wheeler proposes that, in relation to training, PT is seen to have a negative impact on trainees' therapeutic relationship, subsequently affecting their work with clients and treatment outcome. Wheeler suggests that this negative correlation might reflect a therapist who is less confident in predicting a good alliance, but also perhaps because they expect more from the therapeutic relationship than their clients.

A strength of this study is it encourages thoughts about the use of PT in training and of the possible related negative experiences, questioning whether the use of therapy during training is helpful for the developing therapist. As others have found (Rake & Paley, 2009; Marcan et al., 1999, Williams et al., 1999) despite the negative experiences

of personal therapy it was generally thought that even the unhelpful experiences had contributed to some aspect of personal learning- even if it was what *not* to do in therapy. A possible limitation of this study is that counsellors were specifically asked to work with clients who had an eating disorder. This could perhaps have made this client group more difficult to work with, thus the results may have been different if counsellors had been working with clients presenting other symptoms, such as anxiety and depression.

Unhelpful experiences of therapy were also reported in a UK Survey of psychotherapists with 25 respondents who were trainee psychotherapists in the UK (Macaskill & Macaskill, 1992). Participants were asked to complete a 16-item questionnaire to explore their views of their PT experience. Whilst 87% of participants reported PT as having a moderate to very positive impact on their personal lives and work with clients, 38% reported negative effects, including psychological distress (29%), which at times led to depression; marital or family stress (13%), and loss of enthusiasm for PT (13%). The authors suggested that positive experiences emerging in the study were nevertheless associated for some participants with psychological suffering. Trainees found PT to be a powerful and disconcerting experience, with 29% reporting their discomfort as an unhelpful result of therapy, although a further 22% also reported distress but did not regard this as a negative outcome.

The findings from this study appear to suggest that a large part of individuals had experienced unhelpful and distressing in their PT. It would have been perhaps interesting to investigate the difference between negative and positive evaluation of distress, as a way of determining the cost versus benefit ratio of engaging in PT. Further, any conclusions derived from these findings must be drawn cautiously as these are subjective accounts of participants.

Unhelpful experiences of PT have also been reported by Pope and Tabachnick (1994). In a national survey of 476 American therapists the authors found that

participants reported distressing and inappropriate experiences of therapy. Quantitative analysis of the data found that of 84% who had been in therapy, 22% described their experience of therapy as harmful. This included the therapist using inappropriate humour, being unkind or expressing sexual or aggressive behaviour (including shouting). Also, 26% of participants reported being physically cradled by the therapist and 7% stated that their therapist had disclosed their sexual attraction to them, with women participants more likely than men to report sexual approaches.

Negative or harmful experiences of therapy were also reported in Rake and Paley (2009), a master theme that encapsulated this was named "a very dissolving process". Participants disclosed that although they valued PT, they identified some detrimental aspects associated with mandatory PT during training. The lack of explanation from the therapist, unhelpful remarks made and the unsettling nature of therapy were the negative aspects identified. Specific comments made by therapists that were perceived as unhelpful or hurtful were remembered many years later, with associated strong emotional reactions. Participants also reported that therapy as a requirement of training was experienced as enforced and destabilizing, because they felt they had no choice. One participant expressed "I think you can minimise it in your mind and the value of it, because it's taken out of your choice, it's someone else's decision, which I think spoils it in a way ('Fran', in Rake & Paley, 2009).

The previous two sections outline some of the professional and personal benefits of therapy to trainee and qualified therapists, as well as the negative experiences of therapy - which may or may not be viewed as helpful professionally or personally. Given that counselling psychologists do not currently have a requirement to engage in PT post-qualification, and that PT has positive and negative aspects, it is of value to understand the reasons why therapists choose to (or to not) engage in therapy.

2.6.3   Therapists' reasons for engaging (or not) in personal therapy

A review of the research literature reveals that most therapists engage in therapy at some point during their professional career. A USA-based study involving more than 8000 therapists found that 75% of mental health professionals, regardless of their specific discipline, have engaged in therapy themselves at least once (Norcross & Guy, 2005). The reasons provided for engaging (or not) in therapy are varied and have been investigated by Norcross & Connor (2005). They reviewed five studies dating between 1965 to 1988 which investigated the reasons therapists engage in therapy. They found that in the majority of studies (50-67%) therapists had entered therapy because of personal reasons including personal growth and personal problems; and a minority of therapists (10%- 35%) reported seeking PT for training or professional purposes. Similar findings were also reported by Orlinsky and colleagues (2005) in an international study of 5000 psychotherapists. They found that the majority (60%) of therapists, from 10 out of 14 countries, reported seeking PT for personal growth, followed by personal problems (55%). A smaller percentage (48%) reported seeking therapy for professional training purposes. When engaging for personal growth, participants reported that it was not just to focus on difficulties they were experiencing, but also as a way for self-development. However, whether PT was engaged specifically because of a training requirement was not reported.

Whilst the benefits of these above quantitative studies include the uncovering universal truths by collecting data from a large sample of individuals and generalising these findings, some of the limitations of this type of research are that findings are very general and usually less detailed and rich in content. Quantitative studies are considered as being more content- driven, concerned with the uncovering of causal and predictable relationships. Conversely, qualitative studies are considered to be process-driven, concerned with uncovering how individuals assign meanings to their experiences and

circumstances, as well as meanings embedded in text or objects (Hesse-Biber & Leavy, 2011).

More detail about therapists' reasons for engaging in PT was provided by Daw and Joseph's (2007) qualitative study investigating UK clinical psychologists' and clinical psychologists', counselling psychologists, counsellors and psychotherapists experiences of, and reasons for seeking therapy. A total of 48 participants were interviewed, of which 38 were female (aged 28-63) with post-qualification experience ranging from two months to 32 years. Interview transcripts were analysed using IPA. The most cited reasons for engaging in therapy were personal growth (81%), to manage personal distress (75%), to prevent burnout (31%), and to foster self-reflection as a practitioner (9%). Participants reported engaging in PT for personal growth which some participants referred to as being able to recognise patterns in themselves that were unhelpful and to change these, developing deeper insight into themselves and motivations held, and a psychological understanding of internal processes. Personal therapy was also engaged in as a way to manage personal distress arising from personal issues, following major life events, and stresses generated from clinical work. Some participants reported how therapy helped when they became aware of how issues clients present in therapy reflected closely their own experiences, making it difficult at times to separate one's experience from the client's Further, PT was sought as a place that fostered self-reflection on oneself as a person and as practitioner. Participants felt that therapy enabled them to think about how issues with their clients impacted them personally and how this could play out in therapy.

If it is not a training or ongoing professional requirement, therapists may also choose not to seek therapy, and some research has been conducted that sheds light on the reasons why therapists may not engage with therapy. For instance, embarrassment, loss of status, and difficulty finding a therapist who was sufficiently separate from

either a personal or professional context have also been cited as reasons for not seeking therapy (e.g., Barnett & Hillard, 2001; Deutsch, 1985).

Gilroy, Caroll and Murray (2002) surveyed 425 counselling psychologists from the American Psychological Association about their experiences with depression and treatment. Most of the participants (62%) self-identified as depressed and 34% as non-depressed and worked in private practice (64%). Therapists were asked whether they had experienced depressive symptoms as clinicians and whether they had sought treatment or not for such symptoms. Those who did not select to seek therapy they were asked to rate amongst five most salient reasons: depressive symptoms went away, non acceptable therapist nearby, sought alternative coping strategies, concerns about confidentiality and financial cost). Among the men who had experienced depression 62% had sought treatment for their depression and 37% had not. Of the depressed women 71% had sought treatment and 25% had not. No difference was found between women and men's reasons for not seeking therapy, except for one. Female psychologists who selected not to seek therapy expressed more concern with issues of confidentially. What this study failed to report was information about the non-depressed therapists despite reporting that 34% of the sample was. It would have been interesting to know whether the non-depressed therapists sought therapy or not and whether they would seek therapy in the future.

This study reveals how professional factors might affect a counselling psychologist's decision to engage with PT post-qualification, should they be experiencing psychological distress, such as depression. Concerns about how their competence or ability to help others might be judged by another therapist, as well as possible distrust in the confidentiality of the therapeutic relationships both relate to the ethics of the therapist who is giving the therapy. The therapist should be trusted to maintain absolute confidentiality, and be able to determine when and if it is necessary to

act by raising concerns to relevant professional bodies about the competence of their distressed client to practice ethically and safely.

Studies have also been conducted with therapists who have not previously engaged in therapy. For instance, Norcross, Bike and Evans (2008) collected quantitative data from 727 psychologists, counsellors and clinical social workers in the USA, 119 of whom had never sought PT. Participants were provided with a questionnaire and were asked to rate (on a 5-point Likert scale) a range of potential reasons for not seeking therapy, and the possibility of seeking therapy in the future. The reasons for not seeking therapy included managing stress in alternative ways, receiving sufficient support from family and friends, and solving the issue before therapy was considered necessary. Among the top five most reported reasons for not engaging in PT were: managing stress in alternative ways; receiving support from family and friends; coping with challenges alone; solving the issue before therapy was considered necessary; and not needing PT. The lowest rated reasons included: inability to find a therapist with whom they felt comfortable with; inability to locate a good therapist; and feeling discouraged due to peers unsatisfactory experiences.

In this study, the participants who had not experienced therapy expressed less positive attitudes towards its value. Given that all participants offered therapeutic support to clients, this raises the issue of working congruently: can a therapist convey hope that therapy will be useful for a client if they don't believe it would be useful for themselves? If experiencing therapy is more likely to increase positive expectancies about the benefits of therapy, might this point to the importance of therapists needing to be engaged in therapy during their career?

Many of the reasons why therapists might be reluctant to engage in PT and the alternative sources of self-care and coping strategies used by therapists will often be shared by their own clients. Tangentially, therefore, therapists' own *avoidance* of

therapy can also add to their professional development because it also illuminates issues that their clients might experience.

2.6.4 The role of the therapists' therapeutic orientation in their engagement with personal therapy

There is some evidence that suggests that the prevalence of engagement in therapy among therapists following training varies with their theoretical approach (Norcross & Guy, 2005; Orlinsky, Schofield, Schroder & Kazantzis, 2011). Psychoanalytic and eclectic therapists are more likely to seek therapy, compared to therapists of cognitive or behavioural approaches (Liaboe, Guy, Wong & Deahnert, 1989). Pope and Tabachnick (1994) reported a similar trend in their findings. Among their sample of 476 therapists, they found that 94% of psychodynamic therapists were more likely to have been in therapy after training, followed by 87% of eclectic therapists, 79% of other therapists and 71% of cognitive-behavioural therapists.

Orlinsky, et al. (2001) also found that the prevalence of PT following training varied in relation to theoretical orientation. Among a sample of nearly 4000 therapists, 94% of psychodynamic therapists had engaged in PT following training, compared with 91% of humanistic therapists and 73% of cognitive-behavioural therapists. These findings appear to reflect the stronger role of PT for ongoing self-exploration for analytic therapists, than for humanistic or CBT therapists. As well, many of the studies that are included in this review make no distinction between participants being qualified or trainees and so the results may be confounded by the training requirements for mandatory therapy in certain disciplines and orientations.

Interestingly, a survey of 167 counselling psychologists in the United States, investigating their personal experiences with depression and treatment Gilroy et al., (2002) discovered that regardless of their own theoretical orientation, 40% were more likely to engage in psychodynamic therapy, followed by 19% who would seek gestalt

therapy, 12% a cognitive or behavioural approach, and 11% selecting a humanistic approach. Similar findings were reported by Norcross, Bike and Evans (2009), who found that among 608 psychologists, counsellors, and social workers, the majority preferred a therapist that worked in an integrative way, followed by psychodynamic, then cognitive-behavioural approaches. Interestingly participants in this study chose to engage in long-term therapy to explore their personal and/or professional issues, compared to more short-term solution focused therapy. It would have been of value to capture participants' reasons for their decision in selecting one therapeutic approach over another, or for future research to explore this issue.

2.7   Literature on Personal Therapy in the Context of Counselling Psychology

To date, most studies on therapists' PT following training have been conducted in North America, with only a limited amount in the UK. While in North America many therapists have been trained in psychology or medicine, this is far different from the case in the UK where therapists may have had previous training in a variety of fields including; nursing, social work and science, thus making direct comparisons with UK therapists difficult (McLeod, 2006). Furthermore, most of the research reviewed thus far has been with trainee counsellors, psychotherapists and clinical psychologists. Those studies that have included qualified professional therapists have mainly focused on investigating their experiences of therapy or have explored their views of PT as a training requirement.

In the UK, only three studies have focused on the therapy for qualified counselling psychologists (Grimmer & Tribe, 2001; Rizq & Target, 2008; Williams, Coyle & Lyons, 1999). All three of these studies focused predominantly on qualified counselling psychologists' experiences and views of therapy, how this contributed to their clinical practice and personal development, and their views of PT for training.

These studies have not explored how counselling psychologists view the potential role of PT in the context of continuing professional development *post-qualification*.

Williams, Coyle and Lyons (1999) surveyed 84 qualified counselling psychologists, aged 30-74 (median 49), of which 68% were female and who had been practicing an average of eight years. The participants represented a range of theoretical orientations, including psychodynamic, humanistic, integrative, existential and cognitive-behavioural. The number of therapy sessions they had received ranged from 20 to 1600. The study explored participants' understanding of the process and outcome of the therapy they engaged in during training on their professional development, and the contribution of in-training therapy to their practice, and their views of when therapy should be engaged in (before, during and beyond training). The study also aimed to explore whether counselling psychologists select therapists who are similar to themselves in terms of age, gender and theoretical orientation.

The analysis of data indicated that the majority of participants (88%) supported the idea of PT being mandatory for counselling psychology trainees including 69% of those who had reported negative effects. Only 6% of participants said that it should not be mandatory. In regards to timing of PT opinions varied with, 21% being in favour of trainees engaging in therapy before, throughout and beyond training; 17% stated during training for a limited number of sessions; 15% stated during training and beyond; and 13% said at the start of training for a minimum amount of sessions. Twenty-nine participants were in therapy during the research study, 81% said that they would consider therapy in future and 6% said that they would not seek therapy.

Most participants held the same theoretical orientation as their therapist, although participants were equally likely to have chosen a female as a male therapist, regardless of their own gender. In regard to the aims and motivation of therapy, 18% of participants engaged in therapy for training purposes only, 49% reported having no

discussions with their tutors about their therapy, but believed that they would have found them helpful, and 70% had found a forum on PT helpful. In terms of outcome of therapy, 62% of participants expressed a positive outcome, 27% negative, and 11% uncertain. The positive benefits of therapy formed three broad areas: increased ability to deal with personal issues; dealing with problems due to training; and (most commonly) learning about therapy. The highest percentage of positive factors attributed to personal therapy were: personal development and dealing with personal issues (77%); the working alliance (74%); understanding the therapeutic process (73%).

Conclusions drawn from this study were that PT made a positive contribution to the well-being of trainees, by reducing the stresses involved in the profession and acting as a model for professional learning. A benefit of this study is that this study investigated therapy for qualified counselling psychologists, not only during training but asking also perspectives of PT beyond training for counselling psychologists. A limitation of this study is that responses on a Likert scale provide less detailed and relatively simplistic results. A richer level of information could be useful to provide a deeper understanding and knowledge about the process of PT which is very intricate and subjective. For instance, the authors reported that 15% of participants expressed that therapy should be engaged in beyond training, and it would have been interesting to examine this result in more detail, by exploring the reasons for these participants endorsing post-qualification therapy for counselling psychologists. Similarly, it would be useful to understand the reasons why some participants who had negative outcomes of their therapy during training still felt that mandatory PT was important? For example, were there situations in which they were still able to learn from the negative experience of therapy in a way that improved their practice? Further, information about the negative outcomes of therapy that were experienced would also be of value. A mixed-

method methodology that included some qualitative data may have been more sensitive to capturing and uncovering participants' unique meanings and experiences of therapy.

In one of the few studies in this area that has implemented a grounded theory (GT) approach for data analysis, Grimmer and Tribe (2001) explored the views of seven trainee and seven recently qualified counselling psychologists on the impact their in-training therapy had on their professional development. All participants were female, ages between 27 and 53 years, from humanistic, psychodynamic and cognitive-behavioural orientations. They had all engaged in the mandatory 40 hours of PT during their training. Experience of therapy prior to training varied between no experience and two years. Participants were asked one focal question about their experiences of mandatory PT during training and its impact on their professional development.

A GT analysis of the data indicated that mandatory therapy contributed positively to various aspects of professional development. Four core categories emerged: reflection on being in the role of the client and gaining a better understanding of the therapeutic process of their client through reflection on their own experiences; socialisation into a professional role, through validation and experiences of modelling their own therapist; emotional support during times of crisis; and personal development, that included an increased ability to reflect upon personal issues and distinguish these from those of the client. An important finding was the validation of therapy as an effective psychological intervention, particularly for those participants with little previous experience of therapy.

The strengths of a GT approach are that it offers a detailed and rich understanding of the topic- PT- from counselling psychologist's experiences and perspectives. As GT is focused on understanding the meaning of the experience or situation from the participant's viewpoint, this study compared to Williams et al., (1999) offers a more descriptive picture of therapy. Some limitations of this research

that could be of importance are that all of the participants were female and ethnicity was not recorded, meaning that men and ethnic minorities were under-represented. Inclusion of a more diverse group of participants may have produced different results, and would also be more reflective of the diversity in the counselling psychology profession. Also, participants were either recently qualified counselling psychologists or trainees, whose experience of therapy may be more limited as a consequence. It would have perhaps been interesting to explore how trainees felt about their therapy during training and whether it was integral to the training itself, and if their experience of therapy during training impacted in any way on their decision to later seek therapy. Also, as the authors suggest, it could be of importance to explore the role of PT and its contribution to professional development, taking into consideration clinical practice, supervision and academic study.

A third study conducted in the UK with qualified counselling psychologists and exploring PT was conducted by Rizq and Target (2008). The authors investigated the role of PT in the clinical practice and training of experienced counselling psychologists working in private practice and/or the NHS. Nine counselling psychologists (three men and six women), with ages ranging from 42 to 65 years and of various orientations (gestalt, humanistic, psychoanalytic and integrative) took part. All participants were Caucasian, and the length of time participants had spent in individual therapy varied, from 15 months to 14 years. Participants were asked about their experiences of therapy and their opinions about the use of this within the current training. Transcribed interviews were analysed using IPA (Smith, 1995) and revealed five master themes: PT is integral to training; PT is an arena for professional learning; PT provides an arena for intense self-experiences; PT establishes self-other boundaries; and significance of self-reflexivity.

The conclusions reached from this study are that therapy is considered to be a vehicle for an authentic, in-depth relationship with the therapist, through which it enabled them to develop an authentic relationship with their clients, and a sense of emotional and professional resilience in their clinical practice. Although there was some uncertainty regarding the aims and impact of therapy, all participants were in favour of PT remaining part of UK counselling psychology training programmes. A further finding was that the development of a reflexive self in early childhood appeared to be connected with the need to understand difficulties present in the family or in the social environment. This study, as the authors acknowledge, did not report any negative views on PT. These may have been valuable to examine, given the often painful experience of therapy. It would have also been interesting to examine under which circumstances therapy was engaged in, and their thoughts on the role of therapy not only for trainees but also for qualified professionals. However, this study does not particularly focus on how qualified counselling psychologists understand or make use of therapy post-qualification, their reasons for seeking therapy or not, and their views of this being a mandatory part of CPD.

2.7.1 Summary of the extant literature on personal therapy in the context of counselling psychology

Whilst there are limited studies that specifically focus on the use and experience of therapy by UK counselling psychologists, these studies contribute further understanding about the role of PT and its usefulness for developing counselling psychologists, and more generally therapists, in their clinical practice. There are several limitations of these studies. Although these studies do explore and acknowledge the role of therapy as a factor contributing to the personal and professional development of the trainee and qualified counselling psychologist, they do not specifically examine the role of PT for the qualified counselling psychologist and its potential role for CPD.

Further, when reviewing these studies certain considerations need to be made. First, comparisons between the studies reported are to be drawn tentatively, as not all the research studies employ the same methodology and they do not necessarily have comparable sample sizes. Second, many if not all the participants are Caucasian. Although this may reflect the predominant ethnic background in counselling psychologists, findings may not necessarily be applicable the whole of the counselling psychology profession which includes counselling psychologists from other ethnic backgrounds. Third, most of the participants had engaged in therapy that aligned to a psychodynamic or humanistic therapeutic orientation, with the experiences of personal cognitive-behavioural therapy limited, thus not reflecting all theoretical orientations.

What is of relevance is that many of these studies focus on the effectiveness of therapy for therapists and its impact on clinical practice (Bellow, 2007; Daw & Joseph, 2007; Grimmer & Tribe, 2001; Rake & Paley, 2009; Rizq & Target, 2008), rather than on qualified counselling psychologists' perspectives of PT and its role beyond training as a means of maintaining ethical practice and as CPD.

2.8   Rationale and Aims of the Present Research

The research on therapists' own therapy is relatively limited, and the majority of studies that have explored the use of therapy by qualified therapists have been conducted in the USA. It is unclear how applicable many of the findings may be for counselling psychologists in the UK, due to potential differences in training, regulation and professional values. This study will add to the extant literature on the use of PT by qualified therapists, by focussing on a specific professional discipline – counselling psychology – and a UK sample.

This study has three aims: (i) To qualitatively explore the reasons that counselling psychologists engage (or not) in PT post-qualification; (ii) to understand how counselling psychologists view PT in terms of contributing to their professional

and personal development, and (iii) to examine counselling psychologists' views of PT a possible CPD activity. It was hoped that the findings of the study would provide some insight into how and why counselling psychologists use PT once they are qualified, and open a debate about the potential role of therapy as an ongoing (voluntary or compulsory) activity for qualified counselling psychologists. As PT is viewed as an important (and therefore compulsory aspect of training), so too might it provide one means of maintaining professional standards, coping with professional and work-related issues, and ensuring safe and effective practice for qualified psychologists. It is hoped that this research will provide some insight into the meaning and role that PT might also have for qualified counselling psychologists. In turn, this information can add to the wider literature about professional practice, and potentially inform the evolution of CPD requirement in the regulation of practitioner psychologists in the UK, and other counselling and psychotherapy professionals.

As this is a novel research topic, a qualitative approach will be used which it is hoped will provide some initial findings that can stimulate further research in this area. The following chapter describe the epistemological basis of the selected qualitative methodology, grounded theory.

3. METHODOLOGY

This chapter outlines the epistemological basis for the present research, which underpinned the decisions that were taken when establishing an appropriate methodology that would be best suited to meet the aims of the research. The selected methodology - constructivist GT – is presented, and the chapter concludes with a discussion of the role of reflexivity in qualitative research, and methods of evaluating qualitative research.

3.1   Research Paradigms

Decisions about research methodology are determined by the theoretical paradigm that underpins the research, which sets the context for the study (Ponterotto, 2005). The choice of methodology is also influenced by the researcher's ontological (i.e., about the nature of our existence and what constitutes reality) and epistemological (i.e., the nature of knowledge and how we come to understand reality) position (Crotty, 2003; Guba & Lincoln, 1994). Crotty (2003) argues that whether a researcher chooses to conduct a qualitative or quantitative study is not an issue, but what is concerning is to endeavour to adopt two contrasting epistemological and theoretical perspectives.

The dominant philosophical paradigm underpinning most psychology research is positivism (McGrath & Johnson, 2003). Positivism is based on the philosophy of realism, where reality or truth can be discovered through systematic observation and description of a phenomenon (Crotty, 2003). From an epistemological position, the positivistic paradigm argues that reality can be discovered through rigorous methods, by adhering to the hypothetico-deductive method in which the use of tightly controlled experimental studies and the use of statistical procedures to test a hypothesis is essential (Cacioppo, Sermin & Bernton, 2004). Similarly, by maintaining scientific rigour, it is assumed that the research and participants remain independent of each other such that

the phenomenon under investigation can be studied by the researcher without bias (Ponterotto, 2005).

Post-positivism also assumes that an objective reality exists that can be measured, but acknowledges that reality can only be measured imperfectly and one can never fully capture a true reality (Guba & Lincoln, 1994; 2005). This is also known as critical realism (Ponterotto, 2005). Post-positivism recognises that the researcher is likely to have some influence on the participants and cannot remain truly independent of them. Nevertheless, both positivists and post-positivists attempt to adhere to strict scientific methods where variables are controlled or manipulated, to obtain a truth and where the researcher's influence or bias is eliminated.

The paradigm that underpins the present study - constructivism-interpretatvism – is based on a relativist ontological position that does not attempt to uncover a single reality but instead recognises that multiple and equally valid realities co-exist (Crotty, 2003; Schwandt, 2000). The epistemological basis of constructivism-interpretatvism places importance on the dynamic interaction between the researcher and the participants, where the researcher attempts, as much as possible, to enter into the participants' worlds to understand an experience or a phenomena (Ponterotto, 2005). In this viewpoint, socially created knowledge and meanings are considered to be connected to a particular time and context. Thus, it is less important whether a different researcher looking at the same interview transcripts might arrive at different themes, as both may be valid. (Morrow, 2005). Rather, internal and external validity (or credibility and transferability) of the findings are achieved by providing a rich description of the researcher, the participants, the social context, and the process to enable the reader to determine how the findings may be transferable (Morrow, 2005). Although objectivity is crucial in quantitative research to determine an observable and measurable reality

without the researcher bias, in qualitative research the individual rich description of a phenomenon and the meanings co-constructed with the researcher are paramount.

Social constructionism falls under the interpretative paradigm that views multiple realities existing and constructed through social interactions. The use of qualitative research methods is favoured when investigating social processes, as these emphasise the rich description and interpretation of a phenomena in a specific setting (Denzin & Lincoln, 2000).

3.2   Quantitative and Qualitative Methods

Qualitative and quantitative methods differ in their philosophical assumption about the nature of knowledge and truth. Quantitative research methods are rooted in positivistic paradigms and primarily focus on testing out pre-determined hypotheses with the aim of determining universal laws or uncovering a truth through systematic observation. Quantitative research is *nomothetic*, utilising large samples to uncover general patterns of behaviour, with the goal of predicting or explaining a phenomenon and to generalise findings to a population (Denzin & Lincoln, 2000; Morrow & Smith, 2000; Ponterotto, 2005; Silverman, 2013).

Qualitative research is *idiographic* focusing on understanding one or very few individuals, with the aim of gaining an in-depth understanding of a phenomenon through a very detailed and rich description of those studied, generally producing knowledge specific to a small group of people (Morrow & Smith, 2000; Silverman, 2013). Qualitative research aims to investigate individuals' social interactions and their experiences in a specific context, and findings are presented in the language of those being studied to remain close to their own meanings and understandings (Morrow & Smith, 2000; Ponterotto, 2005). Qualitative research adheres to a constructivist-interpretative paradigm because it considers reality as socially constructed by each individual, and as a result there are many possible interpretations of what constitutes

reality. Rather than endeavouring to remain as a detached objective observer, the qualitative researcher is seen to shape the research process, from data collection to the interpretation and presentation of the findings, by interacting with participants and the data (Willig, 2013).

There are strengths and limitations to both qualitative and quantitative research methods. 'Orthodox' quantitative methods can be useful in determining the frequency or probability of a phenomenon, establish causal relationships and make predictions. However, these methods give insufficient attention to participants' views and experiences, and downplay the influence of researcher bias on the research process (Crewell, 1998, 2007). On the other hand, whilst a strength of qualitative approaches is their emphasis on understanding meaning and perspectives, they are criticised as being too subjective, and, due to the small sample sizes, limited in how findings can be generalised (Crewell, 1998, 2007). However, qualitative research methods are considered to be the most appropriate to investigate and to understand the meanings that individuals attribute to events (Morrow, 2007). Moreover, because qualitative research is exploratory in nature it is well suited to explore novel areas of research, new participant groups, where little is known about the phenomena under investigation (Creswell, 1998; Denzin & Lincoln, 2000).

Qualitative inquiry is focused on generating new insights and understandings of how people construct meanings and knowledge through their social interactions (McLeod, 1997). It is, therefore, less interested in finding causal relationships in the world or in making predictions, as quantitative research predominantly is. Instead qualitative research is interested in uncovering the intricacies of human social life and behaviour. Qualitative research methods are considered to be suitable for exploring the human and social field as they offer a set of flexible methods which are well suited to

investigate how knowledge and understandings are constructed by individuals (McLeod, 2011).

A qualitative research method was considered more suitable than a quantitative study, because the aim was to capture counselling psychologist's detailed descriptions of PT and their subjective meanings attributed to this. Conversely, quantitative research, as it is mostly aimed at establishing patters and recurrences can be used to expand, verify and perhaps search to generalise previous findings from qualitative research (Denzin & Lincoln, 2000). As noted in the literature review, studies in this area are sparse making this a further point why a qualitative research method was considered to be the most suitable for this study as it would allow for some new ideas to emerge which could then be potentially expanded upon in future research.

3.3   Rationale for a Qualitative Method in Counselling Psychology Research

If one wanted to know whether one drug is more effective than another, then a double-blind clinical trial would be more appropriate than grounded theory study. However, if someone wanted to know what it was like to be a participant in a drug study [...], then he or she might sensibly engage in a grounded theory project or some other type of qualitative study (Strauss & Corbin, 1998, p.40).

Counselling psychology research is considered by some authors to be dominated by quantitative research methods anchored in positivistic and post-positivistic research paradigms (Denzin & Lincoln, 2000; McLeod, 2014, Rennie, 2002). However, there is a growing trend for the implementation of qualitative methods in counselling psychology research, the publication of which counterbalances the prevalence of the quantitative method in the field and broadens the scope of what knowledge is available to inform the professional practice of counselling psychologists (Ponterotto, 2005).

With the integration and exploration of post-modern perspectives and applied pluralism in practice and in research, counselling psychology has become more

associated with an integrative framework. Consequently, a number of therapeutic traditions are embraced within the discipline, including humanistic, psychodynamic, and cognitive-behavioural, with many practitioners utilising integrative approaches (Strawbridge & Woolfe, 2010). Similarly, counselling psychology is open to a range of qualitative and quantitative research methodologies that can be used to evaluate the efficacy of therapies, or explore the experiences of counselling psychologists and their clients, and generate new understandings about humans and the world. Henwood and Pidgeon (1995) suggest there is a need in human science research to be sensitive to participant's own understandings, as seen from their local frames of reference, or from inside their own socially situated phenomenological worlds. Indeed, qualitative research and counselling psychology share many common qualities and concerns: an attitude of openness, a focus on people's descriptions of experiences and events, and the meanings attributed to these (Coyle, 1998). However, even in counselling psychology, the choice of methodology should be based upon a decision regarding which would best answer a given research question to meet the aims of the study. Thus, to explore the efficacy of a cognitive-behavioural intervention and to determine whether it would be a cost-effective beneficial treatment, a quantitative, preferably randomised controlled study may be better suited (Barret, Byford & Knapp, 2005; Proudfoot, 2004; Foroushani, Schneider, & Assareh, 2011). If the research question related more to lived experiences of (e.g., lived trauma) then qualitative methods, including narrative or phenomenological approaches, would be more appropriate (Karlsson, Bergbom & Forsberg, 2012; Murdoch & Franck, 2012; Soundy, Stubbs, Freeman & Roskell, 2014).

McLeod (2013) argues that it is crucial to develop research in counselling psychology that is congruent with the practices and values of the discipline itself – that is, the centrality of subjective lived experience, values, emotions, and the role of language in constructing reality (Blair, 2010). If psychologists are 'scientist-

practitioners' (Blair, 2010; Corrie & Callahan, 2000; Myers, 2007) then the use of a qualitative method offers counselling psychologists opportunities to conduct research as 'scientists' that is likely to be more congruent with their therapeutic framework and philosophy as 'practitioners' (Ponterotto, 2005).

The present research was interested in gaining an understanding of counselling psychologists' experiences, meanings, motivations, beliefs and attitudes in regards to their own therapy. A qualitative research methodology was considered to be the best approach, not only to meet aims of the study, but also to align with the researcher's own epistemological position.

3.4   Situating the Researcher in the Present Research

As a trainee counselling psychologist and practitioner of psychological therapies I adopt an integrative/pluralistic approach to therapy to understand my clients' difficulties. This aligns to the postmodern roots of counselling psychology, discovered through academic and experiential learning activities throughout my training, which emphasises employing a range of methods of therapeutic inquiry and practice to meet clients' needs (Cooper & McLeod, 2011).

Integrating therapy with practice-based evidence is a characteristic of counselling psychology's scientific-practitioner model. Through my training I have learnt to appreciate the centrality of understanding the subjective worlds of the person and emphasising human values, but also the need for clear theoretical frameworks and an evidence-base to justify the selection of interventions within my practice. Consequently, the models of therapeutic practice I use have been developed by integrating scientific research with a firm grounding in developing a strong therapeutic relationship with my clients (Blair, 2010; Strawbridge & Woolfe, 2010).

Mills et al. (2006) suggest that researchers utilise a research paradigm that reflects their views and personal philosophies regarding the nature of reality and

knowledge. As outlined previously, I considered that a constructivist GT approach (Charmaz, 2006) would be best aligned to my views – both as an applied counselling psychologist and as a researcher of counselling psychology - regarding the socially constructed nature of reality.

The following section presents the rationale for selecting GT as the most suitable approach to meet the aims of the research, and an overview of the history and development of the approach (Charmaz, 2000; 2006).

3.5   Grounded Theory

Since its introduction as a methodology in 1967 (Glaser & Strauss, 1967), the popularity and use of GT as a valid scientific qualitative research method has increased over a number of social science disciplines (Creswell, 1998; Denzin & Lincoln, 2000; McLeod, 2001; Morrow, 2007). This methodology has been increasingly implemented for psychological research, and is considered to be appropriate for researching counselling psychology (McLeod, 1997).

GT is a distinct method that can be used to develop tentative theoretical models that are grounded in the data, and provides a systematic yet flexible way of creating knowledge in reference to a particular group (Henwood & Pidegon, 2003). This methodology was thought to be a suitable model that could be sensitive to the participants' - from a particular group of counselling psychologists - experience of PT in the present study. In GT there is no concern with the discovery of an ontological 'real' world, but only a focus on how individuals construct knowledge within an individual and social context (Henwood & Pidgeon, 1995).

3.5.1   History and development of Grounded Theory

GT originated in the work of sociologists Glaser and Strauss (1967) and was later developed by Strauss and Corbin (1998) and Charmaz (2000, 2006). With their

book, *The discovery of grounded theory,* Glaser and Strauss (1967) encouraged researchers to develop theories from research grounded in data rather from logically deduced hypotheses. This perspective countered the predominant positivistic methodological assumptions that were based on the belief that truth or knowledge is reached through objective and replicable research designs, quantification of data, and generalisation of knowledge (Crotty, 2003). Glaser and Strauss (1967) developed the GT approach as a systematic method that quantitative researchers – who were familiar with following structure and procedures - could adopt to analyse qualitative data. This seminal work by Glaser and Strauss (1967) was considered to move qualitative research beyond simple descriptive account of participants' views, experiences and understandings. Instead, GT provided an important methodological approach that could be used to construct theoretical explanations for the social processes that were being studied (Charmaz, 2006; Glaser & Strauss, 1967).

Glaser and Strauss (1967) disagreed on the nature of the GT method, but Strauss and Corbin (1998) went on to develop a further version of GT introducing three methods of data coding (open, axial and selective). The most significant difference between the initial version of the approach (Glaser & Strauss, 1967) and the evolved version (Strauss & Corbin, 1998) is the role of the researcher (Denzin & Lincoln, 2000; Rennie, 2000). Glaser advocated for the researcher to enter the research study with few preconceived ideas, and to remain sensitive to the data, rather than to pre-existing frameworks. This was thought to be achieved by avoiding reading the literature a priori to data collection and analysis, as this might generate preconceived ideas in the researcher and subsequently hinder the process of analysis (Glaser, 1992). Strauss and Corbin (1998) disagreed with this view, suggesting instead that the researcher should engage with the literature, as this would increase their theoretical sensitivity and would generate insights and ideas, ultimately aiding theoretical construction. A further

difference between the authors of the traditional GT and the evolved version regards their view of reality. Glaser (1978) considered reality as existing independent and separate from the researcher and that the constructed theories are a representation of reality, whereas Strauss and Corbin (1998) acknowledged reality as being a human construction and that theory is an interpretative process (Denzin & Lincoln, 2000).

GT is an inductive methodology through which, by interacting with the data, theoretical ideas begin to emerge that are grounded in the data. Tentative interpretations of the data are then made from the emerging codes, which ultimately lead to the construction of a theory, not the direct truth (Charmaz & Henwood, 2008). The aim is not to portray an exact picture, but to construct a theory that will offer an interpretative portrayal of the issue. Analysis of the data ceases when no new categories emerge and all themes and concepts have been considered and elucidated, reaching theoretical saturation.

Charmaz (2000) argued that both the traditional GT of Glaser and Strauss (1967) and the subsequent version developed by Strauss and Corbin (1998) are objectivist forms of GT. They both endorse a positivist paradigm and assume that data represents objective facts and truths about the world that are waiting to be discovered by the researcher – so that theories emerge from the data. This approach does not consider the context in which the data emerges and the interaction between the researcher and participants. Objectivist GT assumes that the researcher is able to detach from the research process and minimise or bracket-off any of their own fore-understandings and preconceived ideas, in order to obtain unbiased and accurate data. To address what she considered to be the limitations of these forms of GT, Charmaz developed the methodology and introduced a redefined approach within a social-constructionist paradigm (Charmaz, 2006).

3.5.2 Charmaz's constructivist Grounded Theory

In Charmaz's (2006) constructivist grounded theory neither data nor theories are considered to be 'discovered', but instead it is assumed that "we construct our grounded theories through our past and present involvements and the interactions with people, perspectives and research practices" (Charmaz, 2006, p.10). The researcher is seen to be involved in co-constructing meanings with the participants, and as a result the theory produced constitutes one particular interpretation of the data, rather than a single truth.

This form of GT is part of the interpretative tradition that views data and analysis as created through shared experiences with participants (Charmaz, 2000; Charmaz, 2001). Here, focus is placed on how and why individuals construct meanings and actions in specific situations and contexts (Denzin & Lincoln, 2000; Henwood & Pidgeon, 2003). It is not just the experience of the participant that one attempts to understand, but also how this experience is embedded within hidden situations and hierarchies of relationships (Charmaz, 2006; Ponterotto, 2005).

In constructivist GT, the researcher must be aware of the assumptions that they carry into the research, the social context and the social situation and the impact these may have, as both data and analysis are co-created through the relationship that arise between the researcher and the participant (Charmaz, 2006; Mills, Bonner, & Francis, 2006; Pidgeon & Henwood, 1997). It is acknowledged that this process is predominantly interpretative and that resultant theory depends on the researcher's interpretations of participants' meanings and actions (Charmaz, 2006).

3.5.3 Rationale for the use of constructivist Grounded Theory for the present study

Constructivist GT has been used as a research method extensively in the disciplines of psychology, sociology, health and social care (Mills, Bonner & Francis, 2006). Within counselling psychology, GT has also been implemented to research

children's views on undergoing surgery, therapists' reflections on individual therapy, and the process of becoming a therapist (Ford, 2010; Robert, Elliott, Buysse, Loots & De Corte, 2008; Trotta, 2014).

This decision to use constructivist GT was taken following a comparison of not only the various forms of GT, but also other possible qualitative methodologies, as reviewed in the following section.

3.6 Consideration of Alternative Qualitative Methodologies

Other alternative qualitative research methods were considered, and ultimately rejected, when determining an appropriate methodology for the present study. These were interpretative phenomenological analysis (IPA: Smith, 1996), discursive psychology (DP: Potter & Wetherell, 1987; Edwards & Potter, 1992), Foucauldian discourse analysis (FDA), and narrative inquiry (NI).

IPA is a qualitative research method developed by Smith (1995) that is concerned with describing participants' lived experiences of a concept or a phenomenon (Creswell, 2006). IPA (Smith, 1995) and GT (Charmaz, 1996; Charmaz, 2006; Glaser & Strauss, 1967) share some similarities. Both approaches require interviewing a relatively small number of participants, the interviews are usually in-depth to capture the meaning that participants attribute to a phenomenon, interviews are then transcribed, and themes are derived from the data. Both IPA and GT also offer insights into how a person, in a given context, makes sense of a given phenomenon. The exploration of the individual's personal perception of a significant issue is highlighted in both methodologies in similar ways.

Despite their similarities, there are differences between IPA and GT. IPA has its theoretical foundations in phenomenology, a philosophical stance influenced by the ideas of Husserl, Heidegger, Satre, and Merleau-Ponty (Creswell, 2006). IPA is concerned with the in-depth exploration of how individuals perceive and make sense of

their lived experiences, aiming to arrive at the essence of a phenomenon (Creswell, 1998, 2007; Smith & Osborn, 2008). In IPA, the researcher is required to suspend any judgements on the topic under investigation, in order to focus on what is actually presented, this process is also known as 'bracketing' (Husserl, 1999, cited in Spinelli, 2002).

Conversely, GT has its theoretical roots in social constructionism and is a method for developing theories about the world and how people construct their roles and meanings within their social context (Charmaz, 2006). GT views the dynamic relationship between the researcher and participants as pivotal in the co-construction of meaning, and therefore does not require the researcher to bracket him or herself from the research process. In GT the researcher is involved in the research process, moving beyond the description of a phenomenon, and active in constructing a theory emerging from the data (Charmaz, 2006).

Discursive psychology (Willig, 2013) is a form of discourse analysis that views the relationship between different versions of 'reality' (actions, events, and history) and the 'mind' (feelings, desires, and expectations) as central to how people construct versions of these realities through talk and text in social interactions to achieve interpersonal objectives (Willig, 2013). Like GT, DP does focus on conversation and interaction, but rather than viewing language as a reflection of mental events, DP views language as having a social function and being a way to achieve some sort of goal by the person. The method does not focus on social process that influence a particular issue, and does not attempt to develop a theoretical model as does GT. Foucauldian discourse analysis is another form of discourse analysis that places importance on language, specifically its role in relation to power relationships in society (Willig, 2013).

Neither of these iterations of discourse analysis were considered suitable for the present research, because of the emphasis that they place on the role of language and discourses, and how these are used by individuals to construct a social reality. The present study was not concerned with exploring language or written text and its use in disguising possible power relationships and hidden meanings, but rather with gaining new understandings about how counselling psychologists experience PT in a particular social context (i.e., after qualification).

Another qualitative methodology that focuses on language is narrative inquiry (NI), with notable contributors to the development of method including Bruner (1990) and Polkinghorne (1988). In this approach the focus in specifically on the language used by individuals to tell their stories. Autobiographies, letters, interviews and other materials collected to identify how narratives are constructed by individuals and change across cultures and societies. Narrative inquiry, like GT, has its roots in a social-constructionist perspective, but was considered to be less appropriate than GT for the present study because the aim was to understand participant's experiences and perspectives of therapy within a social context (i.e., as a qualified, practicing counselling psychologist), rather than exploring how participants constructed their identities through the use of narratives and stories (Denzin & Lincoln, 2000; Willig, 2013). A more pragmatic reason for rejecting NI as a methodology stemmed from the time constraints on data collection and the subsequent analysis of the data. Researchers using NI will typically conduct lengthy interviews referred to as a 'life-story' interview, each of which can last up to two hours. This process would not have been practical or achievable for the present project.

3.7   Evaluating Qualitative Research

Because quantitative research rests on the assumption that it is possible to replicate studies through consistent measures, the quality of quantitative research is

based upon issue of reliability and validity of the data. Evaluating qualitative research involves determining if the research can be regarded as 'trustworthy' and 'useful' (Smith, 2008). Yardley (2000) proposes a set of core principles and standards that can be viewed as guidelines for evaluating diverse types of qualitative research. These are: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance, and are discussed further in chapter six.

4. METHOD

In the present chapter, the methods and processes that were used to recruit participants and collect data are outlined. Also described are the procedures related to analysing the data in GT which includes information and output from the initial stages of data coding. The method also includes information relating to reflexive practices of the researcher during the research process.

4.1 Research Ethics and Ethical Approval

The present study was conducted in accordance with the BPS Code of Ethics and Conduct (BPS, 2009) and BPS Code of Human Research Ethics (2010), which members of the BPS are expected to abide by. The principles set out in both of these codes guide professional practice, ensuring that researchers respect the rights and dignity of participants who take part in psychological research. The researcher endeavoured to meet these ethical principles when interacting with the participants throughout the research process, including recruitment and interviews. When writing up the findings and presenting participants' views and experiences participants' views, every effort was made to treat individual and cultural differences with respect and sensitivity, and to ensure that information reported remained both confidential and authentic.

The study was approved by Roehampton University Ethics Board members, before data collection commenced (Appendix H). Informed consent was obtained from participants (Appendix B) which ensured that they were aware of the research procedure and issues relating to confidentiality, anonymity, and right to withdraw, and had the opportunity to ask any questions about the study. Participants were informed that the audio recordings and the transcripts of their interviews would only be identifiable to the researcher by a set of codes and that these would be stored securely and destroyed after transcription. Finally, participants were also informed of their right to decline answering

a particular question and that the audio recording equipment could be switched off at any time, if requested. Following the interviews, participants were provided debriefing information (Appendix C), which included the contact details of the researcher in case any follow-up questions arose. As participants were professional counselling psychologists it was deemed unnecessary to provide them with any contact details for support organisations, in the event any concerns were raised as a result of taking part in the research because it was assumed that all participants would have been aware of these themselves. However, participants were informed that if they required details of support organisations these would be provided.

4.2   Participants

Eight (two male and six female) qualified counselling psychologists volunteered to take part in the research. The three criteria for inclusion in the study were that participants: (i) were qualified counselling psychologists, with current registration as both chartered psychologist with the BPS and practitioner psychologist with the HCPC; (ii) had a minimum of three years post-qualification clinical experience; and (iii) had participated in a minimum of 40 hours of PT during their training, as is currently required by the BPS. The rationale for recruiting qualified practitioners with several year's post-qualification experience was that they would have a perspective not only on the role of the compulsory therapy they received during their training but also on any possible need or benefit for continued PT post-qualification. This would place them in a better position to contribute their understanding of the use of therapy as a possible form of CPD. Participants who had not experienced PT post-qualification were not excluded from this research, as it was thought that these participants would also have insight that would contribute to the research aims, namely, the possible role (or not) of PT post-qualification as a form of CPD.

All participants practiced individual therapy, in addition to carrying out other roles such as supervision and professional consultations, and worked in private and public organisations, sometimes across both. Their clinical experience ranged from 10 to 30 years (m=15.6 years). All participants had been trained in an integrative framework. That is, their training had centred upon education, training and experience in more than one therapeutic modality including humanistic, psychodynamic, cognitive-behavioural, gestalt etc., and all of the participants had trained under the earlier pre-doctoral training route to becoming a chartered counselling psychologists with the BPS.

Five participants continued to practice solely from an integrative framework, two utilised a cognitive behavioural framework that was delivered through and underpinned by Rogerian humanistic principles, and one participant practiced cognitive behavioural therapy exclusively. Participants' engagement in PT pre-qualification (which included therapy engaged in prior to their training, as well as the compulsory therapy during their training) ranged from two to 10 years (m=6 years). Their experience of PT post-qualification varied, and three participants had not engaged in any therapy post-qualification, as illustrated in Table 1, that also includes additional participant demographics.

Table 1

Participant Demographics

Participant	1 Bob	2 Joanne	3 Patsy	4 Kate	5 Dave	6 Susan	7 Jan	8 Della
Age	61	62	45	65	39	47	50	65
Gender	M	F	F	F	M	F	F	F
Orientation	Integrative/ Psychodynamic	Integrative	Integrative	Integrative/ CBT	CBT/psychodynamic	Integrative	Humanistic/ CBT	CBT
Years of clinical experience	15	11	17	21	10	10	11	30
Years of PT pre-qualification	10+	3.5	6	5	4	2.5	7	2
Years of PT post-qualification	Ongoing	3	3	None	2.5	No	7 months	None
Work setting	Private practice	Private practice NHS	Private practice NHS	Private practice NHS	Private practice	Private practice NHS	NHS	NHS
Ethnicity	Caucasian	Caucasian	Asian	Caucasian	Caucasian	Caucasian	Caucasian	White other
Other	Disabled/ single	Married/ children	In partnership	Married/ Children	Single	Single/ children	Not stated	Not stated

4.2.1 Recruitment procedure

Given that the entire population of interest in the present study was BPS qualified counselling psychologists, 40 qualified chartered counselling psychologists listed on the BPS website were contacted via email and sent an outline of the research study (Appendix A). To arrive at the initial 40 psychologists, a search was first performed on counselling psychologists based in London. This returned approximately over 200 psychologists. From this initial list of London-based counselling psychologists a more specific search was made to ensure that participants would come from the different parts of London and not the same area, to ensure diversity. Eight psychologists expressed an interest in taking part, all of whom met the inclusion criteria, and were sent the consent form (Appendix B), which informed them of their right to withdraw from the research and the steps taken to ensure anonymity and confidentiality, and a demographic questionnaire (Appendix E), both of which they were asked to complete and return. As recommended by the researcher's supervisor, they were also provided with the interview schedule (Appendix D), to allow them time to reflect upon their experiences of therapy.

4.2.2 Initial sampling and theoretical sampling of participants

One of the distinctive features of GT is the sampling of participants, consisting of two stages: initial sampling and theoretical sampling (Charmaz, 2006). Initial sampling is described as "where the researcher starts", and related to the selection of participants based upon recommended sample size, relevance to the topic, and inclusion criteria.

As GT is aimed towards building a theoretical explanation of a phenomenon, rather than making predictions that can be generalised, small samples are considered adequate (Willig, 2013), with authors recommending as few as six, and a maximum of

30 participants (Creswell, 1998). It was for this reason that 40 counselling psychologists were originally approached, based upon the assumption that a response rate between 15-20% would provide an adequate sample for GT. As outlined above, the initial 40 counselling psychologists were selected based first upon their proximity to the researcher (i.e., were based in London), and also to represent a range of postcode areas within London, which was viewed as one way to seek some socioeconomic diversity in the sample (Charmaz, 2006).

Theoretical sampling, on the other hand, "directs where the researcher goes" (Charmaz, 2006, p.100), and involves recruiting additional participants on the basis of elaborating and refining emerging concepts arising from the analysis of the first interviews (Charmaz, 2000, 2006). This type of sampling allows the researcher to develop emerging theoretical categories, by actively seeking participants who can help the researcher refine and elaborate categories. Through this process, the development of categories continues until no new categories emerge, thus reaching theoretical saturation, or theoretical sufficiency (Charmaz, 2006).

In the present study, five participants were first interviewed, followed by three. As categories emerged from initial analysis of their interview data, three participants (Kate, Jan and Joanne) were asked a further three questions, to generate additional insight about the developing categories. Although all eight participants were approached to answer the additional questions, only three responded. Appendix D includes both the initial interview schedule and the three further questions that were added to it. The process of reaching theoretical sufficiency and the rationale for the addition of further questions is outlined further in chapter 6.

4.3   Designing the Interview

A qualitative interview, used to "enter into the other person's perspective" (Patton, 2002, p.341), was the method of data collection. The interview was viewed as

both a tool for data collection, and a conversation between two individuals - the researcher and participant - within which data is generated (Willig, 2013).

Structured interviews are most commonly used in quantitative studies, because they decrease variance and provide standardisation across responses, and thereby are seen to increase reliability (Merriman, 2014). However, structured interviews do not provide the richness of data that is of interest to the qualitative researcher who seeks to gain access to participants' experiences, meanings and understandings of a particular phenomenon. Qualitative interviews are consequently less structured, with open-ended questions and the use of probes and prompts, to allow the researcher and participants to explore and pursue new avenues should these arise (Willig, 2013).

Unstructured interviews do not reflect any preconceived theories or ideas and are thus often not planned beyond an opening question, "can you tell me about your experience of personal therapy?" and further progress is made based almost entirely upon responses to that initial questions. The limitations of this method for many research projects is that they are time-consuming, often taking several hours, which also imposes more on participants' time and consequently makes it harder to recruit, and can also lead to confusion on the part of the participant as they have little preparation of the topic.

A semi-structured interview is the most commonly used method of data collection used in qualitative research and is considered to be compatible with a variety of qualitative methods (Willig, 2013). This interview format is suitable for a GT methodology because it is both open ended – allowing the interviewer to be flexible and the interviewee to expand on a particular topic, and directive – steering the interview towards the particular research aims or questions (Charmaz, 2006; Willig, 2013). Semi-structured interviews can be adapted during an interview process to explore issues that might depart from the main topic, allowing richer and more realistic information to be

gathered from the interviewees' perspective. This helps to capture a fuller picture of what is being investigated, as interviewees are generally more relaxed, informed and involved in the process (Coolican, 2014).

Among the disadvantages noted of using a semi-structured interview are: the length and depth of the interview process may limit the number of participants willing to commit their time and energy; problems with reliability and generalisation are present, where important topics can be missed if there is no questionnaire to check; and it limits data analysis to qualitative. Further, whilst an advantage of the semi-structured interview consists in its flexibility of applicability and for the researcher to pursue any interesting and unexpected avenues with follow-up questions, this comes with two disadvantages. First, follow-up questions are difficult to interpret, because different participants are asked different questions depending on what they reveal during the interview. Second, even the standard questions are at times difficult to determine between participants, as the questions may have not been asked in the same sequence to all the participants (Schwartz, 1999; as cited in Mitchell and Jolley, 2013). Despite these limitations, using a semi-structured interview for this particular study and topic was considered to be most appropriate because a semi-structured interview allows the researcher to gain a deeper and richer understanding on the topic being investigated, whilst also maintaining focus on the areas that are of particular interest.

A semi-structured interview was prepared (Appendix D), according to the guidelines outlined by Wengraf (2001). Wengraf (2001) recommends the interview schedule begins with several questions aimed to answer the key issues of interest. Questions are then broken down to include further prompts, as a way to facilitate exploration of new emerging avenues. In the present study, the initial questions sought to encourage participants to consider their own experience of therapy post-qualification and how this has affected their personal and professional development (e.g., "how has

your experience of personal therapy been?") and their views of PT as a possible CPD activity post-qualification (e.g., "what are your views of personal therapy for qualified counselling psychologists?"). It was anticipated that the full interview would last approximately one hour.

Besides the pre-planned semi-structured interview questions, other additional questions that arose of out each interview were to some extent dependant on what participants revealed in the process about their experiences.

4.3.1 Interview piloting

The interview schedule was piloted with a newly qualified counselling psychologist, and a colleague of the researcher. Discussions illuminated the importance of considering how experiences of PT during training may affect a practitioner's later attitudes towards therapy once they are qualified.

Whilst the focus of the research was on post-qualification PT as part of continuing professional development, it was not an inclusion criterion that participants had to have engaged in post-qualification PT (and neither is it mandatory that qualified counselling psychologists engage in PT). Therefore, an additional question about in-training therapy was added to the schedule to capture any views participants had about PT, even if their only experience of therapy was the minimum 40 hours completed during their training. This would also add depth to the study by linking pre-qualification therapy experiences with post-qualification views and use of therapy.

A further point made from the feedback of the pilot interview was that the researcher could benefit from using additional prompts and probes, consistent with a semi-structured approach, as she had seemed to follow a more structured approach to the pilot interview. This had not facilitated as much reflection or exploration of the pilot participant's views and experiences, limiting the richness of data that was captured.

4.4   Data Collection

The data collection phase consisted of conducting initial interviews with five of the eight participants, and then the remaining three participants. Interviews were transcribed alongside the data collection process. The analysis of these interviews generated additional questions, which were addressed by interviewing three participants (Kate, Jan and Joanne) a second time to explore some gaps in the emerging theory (Charmaz, 2006; Charmaz & Henwood, 2008).

Data was collected through audio recording the semi-structured interviews, which were conducted in person at venues across London, selected based upon their convenience to each participant. Settings in which interviews took place included private consulting rooms, shared work offices and participants' homes that had an allocated room for their private practice.

During the interview notes were made about interesting aspects of the participants' responses that could be pursued with additional questions or prompts, participants' non-verbal communication, and the researchers' experience of the participant during the interview process. These notes were reflected upon during the analysis phase.

4.5   Data Analysis: Constructing Grounded Theory

Data analysis in GT coding consists of two data coding phases (initial coding and focused coding), as well as the use of memo writing, theoretical sampling, and theoretical saturation. The ultimate aim of constructivist GT is to construct a theory which provides insight into how a particular group of people experience or make sense of a certain situation. A GT analysis can produce two types of theory: a *substantive theory* provides a theoretical interpretation of a particular issue, or a *formal theory* which provides a theoretical explanation to a generic issue and which can be applied in wide range of topics (Strauss and Corbin, 1998). This study can be seen to have perhaps

generated a substantive theory, although this was not decided in advance, but is an observation after the process of analysis.
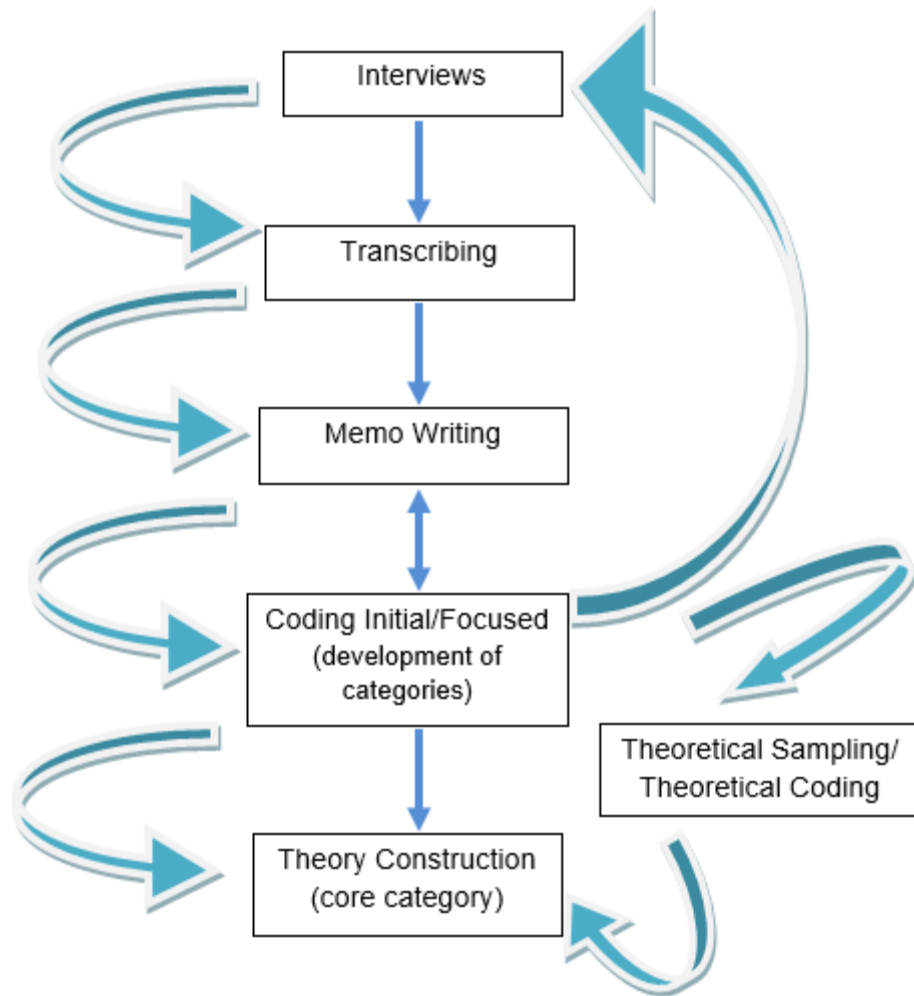
Figure 1. The stages of Grounded Theory analysis (Charmaz, 2006)

4.5.1 Coding the data

There are two stages to the coding of data in GT: initial coding and focused coding. In the initial coding stage each segment of the data selected is named with provisional codes. In the focused coding stage larger segments of data are named that include the most frequently occurring codes. Although these stages may be presented in a sequential manner, coding in GT is flexible, in that it allows the researcher to return to the data time and time again and make new codes (Charmaz, 2006).

4.5.1.1   Initial coding

Initial coding is performed at the level of single words, lines, or paragraphs. This stage involves a detailed reading and re-reading of transcripts, scrutinising the data and naming segments of data with a code that attempts to depict meanings and actions. The use of gerunds (i.e., verb forms which function as nouns ending in *–ing*) is advised to preserve action and process.

Sometimes the names for codes are extracted directly from the interviews, referred to as *in vivo* codes. These are used to remain close to participants' accounts and to preserve the meanings of their views. At this stage codes are provisional and remain open to change, to best fit the data (Charmaz, 2006).

An example of initial coding within a section of a participant's verbatim transcript is shown in Table 2. A fully transcribed interview including initial codes is presented in Appendix G.

Table 2

Extract of an Interview and Initial Coding (Jan)

Interview Transcript	Initial Coding
Well, there are two different things there. Do I think it should be part of one's development as a...as a counsellor or therapist. Personally I think it's important to know how it feels to be on the other side. You can only really appreciate the nature of transference when you experience it from the client's perspective, and then understand countertransference and transference through the professional perspective ...through experience rather than a theoretical approach. I think theory and experience should come together and meet somewhere in the middle, so I do think it's essential...and I think we're underdeveloped as a professional body if we don't develop ourselves. Cos that's the only thing we have. We've got lots of theory, we sit alone in a room...no one knows what we're saying, cos we're taped very very occasionally...and your integrity the ability to deal with and provide boundaries is based on you as a person. You can read as much theory as you like, if you haven't actually felt it then I don't think you'd be a brilliant therapist.	Personal therapy important for the development of the therapist Understanding how it feels to be a client. Appreciating the role of being the client Understanding the counter-transference in the relationship Integrating practical and theoretical experience Under development of the counselling psychology profession, if lacking development of self Using oneself in the therapy Secrecy of therapy sessions Having integrity Not having the experience, but just theoretical knowledge, does not make a good therapist

4.5.1.2   Focused coding

Focused codes are based upon the most frequently occurring initial codes. However, this is not a purely quantitative process, as the researcher must re-read all of the initial codes in detail, to make a decision about which codes to select that most adequately describe larger segments of data. At this stage codes are more directive, selective and conceptual (Glaser, 1978). The purpose of focussed coding is to help the researcher determine "which initial codes make the most sense to categorise data incisively" (Charmaz, 2006, p.57). The process of focused coding allows the researcher to sift through large amounts of data and move between interviews to compare participants' actions and experiences (Charmaz, 2006; Glaser, 1978). An example of focused coding from the present study, is presented in Table 3. The constant comparison method and the use of memos are used to identify recurring patterns and reflect upon the researcher's decision-making in the selection of focused codes (Glaser & Strauss, 1967).

4.5.2   Constant comparison method

The constant comparative method is used to compare and contrast participant's views, experiences and statements (both between and within interviews) and therefore to group similar concepts together. As categories develop they become distinguished and refined into major concepts which contribute to the construction of a theory.

Table 3

Extract of an Interview and Focused Coding (Jan)

Interview Transcript	Focused coding
Well there are two different things there. Do I think it should be part of one's development as a...as a counsellor or therapist. Personally I think it's important to know how it feels to be on the other side. You can only really appreciate the nature of transference when you experience it from the client's perspective, and then understand countertransference and transference through the professional perspective...through experience rather than a theoretical approach. I think theory and experience should come together and meet somewhere in the middle, so I do think it's essential...and I think we're underdeveloped as a professional body if we don't develop ourselves. Cos that's the only thing we have. We've got lots of theory, we sit alone in a room...no one knows what we're saying, cos we're taped very very occasionally...and your integrity the ability to deal with and provide boundaries is based on you as a person. You can read as much theory as you like, if you haven't actually felt it then I don't think you'd be a brilliant therapist.	Importance of personal therapy for the development of the therapist

Integrating practice and theoretical knowledge

Developing ones role as a counselling psychologist

Working professionally and having integrity

Experiencing therapy personally is vital for a good therapist. |

4.5.3   Memos

The writing of memos (memoing) is an important tool in GT (Charmaz, 2006). Memos are written throughout the research process in conjunction with both data

gathering and data analysis. This feature of GT prompts the researcher to develop ideas and new insights, fine-tune subsequent data gathering, and reflect upon decisions that were taking when arriving at focused codes and categories (Charmaz, 2006). In this way, memos helped with the development and refinement of categories and the identification of questions and new leads to pursue (Charmaz, 2006).

In the present study, memos were kept throughout the research process, and particularly after each interview, to elaborate on 'hunches' and ideas. Thoughts, feelings, and the context in which the interviews took place were also recorded as important information. The writing of memos also helped the researcher maintain a reflexive attitude during the analysis phase, to consider themes in detail, and to elaborate on emerging ideas. An example of memo writing, written in the first person, follows.

4.5.3.1   *Memo on "the ideal therapist"*

Reading several of the transcripts over many times, I am becoming more aware of the importance of the role as a 'professional' and the effect this may have on one seeking therapy. One participant spoke openly about her role as a consultant, and how she felt her position impacted to some extent on her decision to seek therapy. She explained how working as a private consultant made her feel that she should be professional enough to get through her difficulty without any support. She also spoke about time constraints as preventing her from seeking therapy in time of need, yet also that she eventually left the job due to professional burnout. This participant expressed that, in hindsight, she could have perhaps engaged in therapy as a means of emotional support. A further participant working on a team of doctors offering psychological therapy, spoke of how one of his colleagues held a very negative view of PT and had not engaged in any therapy himself. This participant reported that when disclosing to a colleague that he was in therapy his colleague replied "why bother?"

The theme of appearing to be without vulnerabilities, or not requiring emotional support, could perhaps be linked to the role of the 'professional' and needing to be the 'good therapist'. Being a professional and in the role of the 'helper' may make it easier for one to accept providing help to others than to receive help in turn. I wondered if having PT available in the workplace could perhaps be seen to be similar as having clinical supervision, proving emotional support for workplace stress and difficulties at work. Envisaging PT in the workplace could also address issues around stigma, accessibility, with some participants stating it was time-consuming to access therapy. Yet implementing therapy at work could raise issues around confidentiality.

4.5.4 Theoretical sampling

The strategy of theoretical sampling in GT refers to the sampling of additional participants, guided by what emerges from the data. The purpose of interviewing new participants is to allow the researcher to seek and collect pertinent data to "elaborate and refine categories in the emerging theory" (Charmaz, 2006, p.97).

Following the production of the initial and focused codes in the present study, the researcher conducted theoretical sampling to develop the emerging categories further. The initial interview schedule in the present study was developed according to the main aim of the research - to explore the processes which influence counselling psychologists to engage (or not) in PT post-qualification, and to understand more about how counselling psychologists view PT as contributing to their professional and personal development, and of PT being a possible activity for CPD - and therefore included questions that were focused on post-qualification therapy. However, five of the eight participants who were interviewed also described how they felt that the compulsory PT they received during their training had not been a good experience and neither had it felt integrated with their training. It was considered that this could be usefully explored to generate an understanding of whether there were links between

(positive or negative) experiences of in-training PT and the use of therapy post-qualification. Consequently, an additional two questions were formulated to explore participants' experiences of compulsory PT as trainees: How was your experience of personal therapy during training? And, did your experience of personal therapy during training influence you later seeking it? A third question was also added: How can personal therapy be better integrated into training programmes? Given that PT is a compulsory part of the training of counselling psychologists in the UK, it was hoped that this final question could shed light on ways in which it could be a more beneficial training activity and a more positive experience for trainees'. These additional questions were asked to three of the original eight participants, as due to time restrictions, it was not possible to recruit any additional participants. This is considered to be appropriate, as theoretical sampling is about explicating the emerging categories rather than sampling to reflect initial research questions, to determine population's contributions or negative cases (Charmaz, 2006).

4.5.5 Theoretical saturation vs. theoretical sufficiency

In GT, theoretical saturation is considered to be reached when data collection produces no new theoretical insights into the core categories, and no more core categories emerge (Charmaz, 2006; Strauss & Corbin, 1998).

Theoretical saturation is not merely a matter of obtaining large amounts of data from large samples. According to Charmaz (2006) the saturation of categories is not dependant on the sample size of the study, as with too much data the researcher may risk becoming overwhelmed and may overlook key aspects in the large volume of data. Whilst Charmaz (2006) considers theoretical saturation as something GT researchers should aim for, Morse (1995) points out that although theoretical saturation is often proclaimed to have been achieved, there are few guidelines that determine how to achieve or confirm saturation. Willig (2014) also states that the researcher should strive

for the saturation of the categories, yet acknowledges that changes in categories and perspectives is always possible in GT. In this sense, theoretical saturation acts like a goal rather than a concrete obtainable state for the data.

Given the ongoing debate about whether such a stable point as 'theoretical saturation' can be reached, or even exists, Dey (1999) introduced the notion of "theoretical sufficiency", proposing that categories in GT are not *saturated from* the data but rather are *suggested by* the data, and that theories are susceptible to change and modifications and not stable entities. Keeping this notion of 'suggestion', 'change' and 'instability' in mind can help the researcher (and reader) avoid making assumptions that there is no more to find or learn from the data, that the findings do not have alternative interpretations, or indeed that the analysis is 'finished'. In GT changes in categories and perspectives are always possible in GT (Willig, 2014) and a GT can be viewed as provisional, where the "published word is not the final one, but only a pause in the never-ending process of generating theory" (Glaser & Strauss, 1967, p.40).

In the present study, a point of theoretical sufficiency was sought, recognising that theoretical saturation represents an ideal state rather than what is possible to achieve in practice (Charmaz 2006; Dey, 1999; Morse, 1995).

4.5.6 Theoretical coding

The final stage of a GT involves specifying possible relationships between the categories that emerged during focused coding, which are then developed into theoretical categories (Glaser, 1978). Theoretical codes increase the explanatory power and completeness of the main categories and the relationships between them, and enhance these to become theoretical constructs. Categories produced through theoretical coding are viewed as "explicating ideas, events and processes in the data" (Charmaz, 2006, p.91).

This stage of coding facilitates the integration of the main categories to aid the construction of a theoretical framework (Charmaz, 2006). Major categories are constructed which relate to one major core category, that sits at the centre of the developed theory (Strauss & Corbin, 1998). The use of memos and diagrams during this stage support the expansion and refinement of the categories and the theoretical links between them, with the aim of generating categories that provide a recognisable description of the data (Henwood & Pidgeon, 2003).

In the present research, the process of continuously inspecting participants' accounts and their meanings, memoing, constant comparison of codes within and between the interviews, and research supervision discussions, led to a point at which no new categories emerged − and it was considered that theoretical sufficiency had been reached (Dey, 1999). Five major categories, representing 12 subcategories were identified which represented one theoretical framework, and lifted the data to a more abstract level. The following chapter outlines these categories and the theoretical framework, with illustrative excerpts from the participants' accounts.

4.6   Researcher Reflexivity

In qualitative research generally, the research and the researcher are not seen as separate from one another, but are considered to be closely linked (McLeod, 1997; Yeh & Inman, 2007). With respect to GT particularly, Charmaz considers the researcher to be undoubtedly part of the theory that emerges, as a result of deeper reflection and interaction with the data, standing "within the research process rather than above, before or outside it" (Charmaz, 2006, p.180).

Because the researcher in qualitative research is considered to be the primary tool of data collection, who actively constructs the interpretation of data, reflexivity is considered essential (Glesne, 1999). Consequently, an integral part of the process of conducting a qualitative research study are the steps taken by the researcher to maintain

reflexivity, and reduce bias through the process of writing notes, memos, recording ideas and hunches throughout the research, questioning the names of the categories (Henwood & Pidgeon, 2003).

Bracketing-off refers to the need in qualitative research for the researcher to hold back any preconceptions that could potentially bias the research process (Merriam, 2014). As Langdridge (2004) suggests one cannot truly bracket all their assumptions and expectations, as the data will undoubtedly be influenced by these. Because of this, there is no single true interpretation of data, but rather subjective, grounded statement that opens up new understandings (Lyons, 2007). Reflexivity can be used by the researcher to continuously scrutinise the interpretations and decisions made throughout the research, and to be aware of how his or her own assumptions and interests influence the research process (Charmaz, 2006).

In the present research, the researcher adopted several processes that supported reflexivity:

A Self-Reflective Journal. A reflective journal was maintained during the entire research process from recruitment through data collection, analysis, and presenting the findings. This documented experiences of the research process enabled the researcher to question her assumptions and presuppositions, and think about the ways in which her involvement may have influenced and informed the data obtained and the interpretations of the data (McLeod, 2003).

Writing Memos. Memoing is considered to be an important process in GT research, as it encourages the research to reflect on codes and categories emerging, and to play with potential abstract concepts. During the writing certain codes or categories may start to stand out, and through constant comparison one can start to make connections between ideas and data. The process and benefits of writing thoughts and

hunches during the entire research project are considered to be beneficial in facilitating thought processes and creating new ideas (Maxwell, 2005; Watt, 2007).

Research Supervision. Research supervision can support and assist researchers, particularly in qualitative research, to be open about their emotional reactions to the research study and to discuss any potential preconceptions and their involvement in the conduct of the study (Davidson, 2004). In the present study, the researcher used supervision sessions to discuss the forming of codes, categories and final core category, gaining a different perspective of these during the analysis phase, and to reflect on whether any pre-existing assumptions, beliefs or biases were entering the research project.

5. FINDINGS

The aims of the present study were to explore the reasons that counselling psychologists engage (or not) in personal therapy (PT) post-qualification, to understand how counselling psychologists' view PT as contributing to their professional and personal development, and to examine counselling psychologists' views of PT as a possible continuing professional development (CPD) activity. A constructivist grounded theory (GT) approach was followed to examine the verbatim transcripts from participants' interviews. Related to these aims, five major categories, representing 12 subcategories, were constructed, and are discussed in turn in this chapter. Excerpts from interviews are presented to enable the reader to determine for themselves the transparency of the research investigation and the validity of the constructed codes, categories and theory.

A summary of the constructed categories and subcategories, and the recurrence of these amongst the participants, is presented in Table 4. The overarching theoretical model constructed – *diverging attitudes towards the role post-qualification personal therapy* - is considered to depict the overall meaning in the narratives of participants. What is presented here is one of many possible interpretations of the data. The constructed categories and subcategories represent the researcher's model of the data which emerged from the narratives, which is part of a socially-constructed reality specific in time, context, and interpretation (Charmaz, 2006).

Table 4

The Recurrence of Categories and Subcategories among Participants

Category	Subcategory	Bob	Joanne	Patsy	Kate	Dave	Susan	Jan	Della
1. Personal Growth versus Personal Crisis	Personal therapy as an intimate space	√	√	√		√		√	
	Learning to identify and work with transference and countertransference	√	√	√	√	√			√
	Personal therapy as a self-care resource	√	√	√	√		√	√	
	Personal therapy when in crisis				√		√	√	√
2. "Practice what you Preach"	Being Congruent	√	√	√				√	
	Alternative methods of self-care		√		√		√		√
3. The Ideal Therapist	Not showing vulnerability	√			√	√		√	
	Seeking a good-fit therapist	√	√	√	√				√
4. Compliance and Confusion of Compulsory PT as Trainees	Lack of emphasis and confusion of personal therapy as trainees	√		√	√	√	√		√
	Ambivalence towards PT as trainees			√	√	√	√		√
5. Approval, Ambivalence and Constraints of PT as Post-Qualification CPD	Favouring personal therapy as part of CPD	√	√	√	√	√	√	√	
	The uncertainty of PT as part of CPD			√			√	√	√
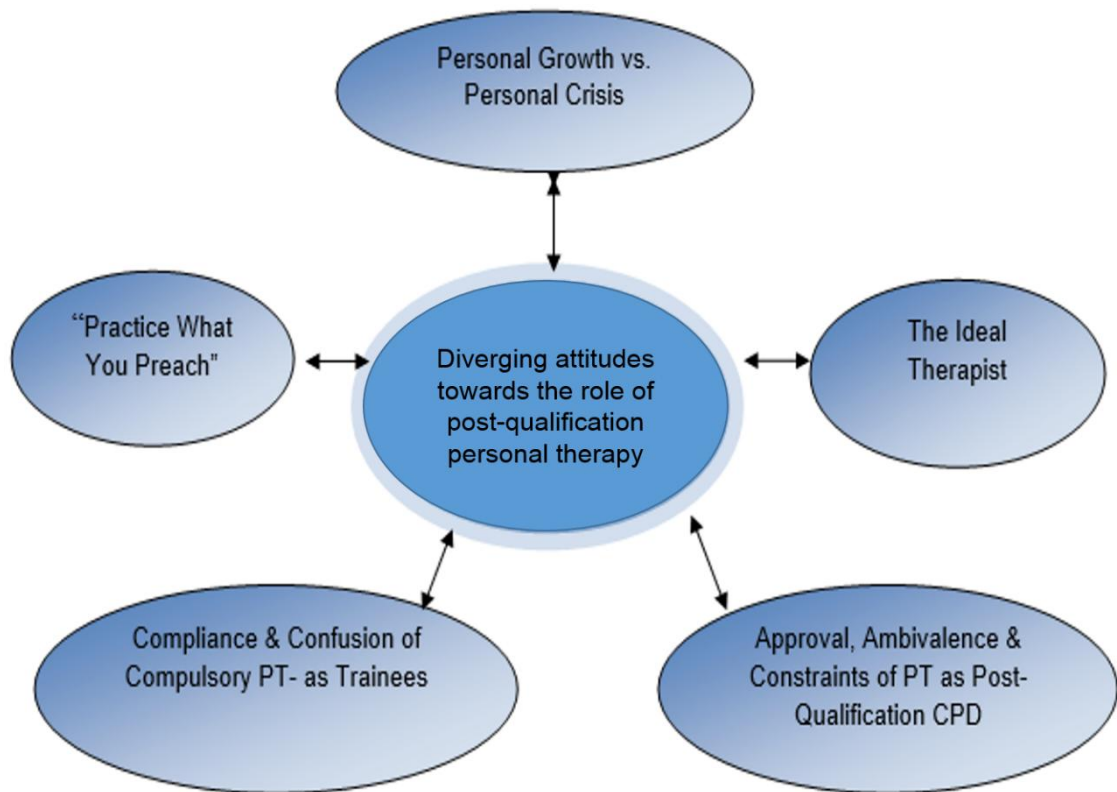
Figure 2. The constructed theoretical framework: Diverging attitudes towards the role of post-qualification personal therapy.

5.1 Category 1 - Personal Growth versus Personal Crisis

Broadly, this major category represents participant's views, experiences, and reasons for engaging in PT as a qualified professional. It is represented by four subcategories: (i) personal therapy as an intimate space; (ii) learning to identify and work with transference and countertransference; (iii) personal therapy as a self-care resource; (iv) personal therapy when in crisis. These subcategories encompass the meanings that qualified counselling psychologists attributed to their engagement in PT.

Personal therapy was described by participants as being an intimate space, differing from their general relationships, which enabled them to uncover deeper aspects of themselves and to identify and work with transference and countertransference that arose in their work with their clients. Several participants reported engaging in therapy

following qualification as a way to resource themselves personally, as a way to foster self-reflection of oneself and of relationships; but also to develop one's professional skills, awareness of the impact of the therapist on therapy, develop sensitivity to how it clients may feel in therapy. Other participants reported that they would seek PT if and when presented with a personal or professional crisis, such as bereavement, relationship, breakdown, loss of a job and difficulty with increasing caseload.

5.1.1 Subcategory 1a - Personal therapy as an intimate space

The five participants who had engaged in post-qualification PT referred to their therapy as a personal, intimate and unique space that is different to and separate from their relationships with friends, colleagues or partners. This relationship was free of the 'clutter' of these other relationships because the attention was solely on oneself. Participants reported PT as a place where they could reflect on themselves at a personal level as well as on themselves as they were in their professional clinical work.

Patsy had engaged in PT post-qualification, and described her experience of therapy as a unique, self-reflective space different from other relationships in her life:

> I liked the sort of uniqueness of the space of being able to go and think about myself and engage with somebody else about what's going on for me and have a space that was kind of - it's not neutral - but it wasn't cluttered with the kind of things that other relationships are cluttered with.

Patsy refers to PT as "neutral", a personal space devoid of any other issues in which she felt able to explore and reflect on herself fostering an attitude of self-awareness. She refers to the relationship with the therapist as being "less cluttered", perhaps referring to this being a simpler relationship than other personal relationships which are often accompanied by expectations, power dynamics, even resentment, and where one has to allow the focus to be upon others.

Jan also referred to her therapy as a different type of relationship to the one held with colleagues and friends. Therapy is a relationship in which she does not fear exposing her vulnerabilities and knows that she will be listened to attentively:

> I had a safe place in which to fall apart completely for one hour once a week for as long as it took until that stopped happening....and I didn't feel I had that with colleagues who I didn't know very well or it didn't seem appropriate. For me, therapy was something completely different to the normal chats one has with friends. My therapist was someone I felt I could show my vulnerabilities to, and I felt contained and listened to.

In this excerpt, Jan talks about PT as a safe place in which to "fall apart", which perhaps implies she is otherwise, outside of therapy, holding herself 'together', or that she is experiencing a crisis. Jan also points out the uniqueness of the dialogue within therapy as being different from conversations with friends, and as being a more appropriate relationship in which to reveal her difficulties or issues than doing so with colleagues.

Joanne described seeking therapy post-qualification during a period of illness, despite having support from family and friends:

> I had lots of space really and I could go there and it was really nice. It was kind of...because it kind of got me away from the whole family of...it was sort of... I felt very constrained some of that time with the illness and it just kind of got me a place where I could just go and get away from it all the sort of family stuff. With my illness, I felt that I had my own private space in therapy where I discussed what I wanted to, and it did not necessarily have to be about my health. I think that at the time it felt like a real outlet from everything.

Joanne refers to her PT as a place in which she felt free to be who she wanted to be, and could talk about more than just her health. Here, Joanne reveals how outside of therapy she felt "constrained" by her illness, and how perhaps she was seen to be defined by or identified as her illness in her relationships with others. In therapy she was able to go beyond her physical health to express other issues and difficulties.

Joanne also views therapy as a place where she could get away from "all the sort of family stuff". This resonates with the "clutter" present in other non-therapy relationships that Patsy mentioned.

Dave, who had engaged in therapy as a qualified counselling psychologist describes how therapy was experienced as a "free space" in which he felt comfortable to be himself, without the need to hide or alter aspects of himself in order to be accepted.

> A very sort of free space just to really say whatever I want without kind of having to filter it and worry about how it is going to be received [...] more kind of a support and an outlet, rather than there is something I need to change. I think what I have realised about relationships, intimate relationships, is you know you can't...it's not appropriate to bring everything and you have to keep some sense of self and support outside of the relationship for the challenges of life.

Here, Dave contrasts his PT with his intimate relationships outside of therapy, and explains how he uses therapy to express himself more freely without censoring himself. For Dave, therapy seems to provide two important purposes: it protects his intimate personal relationships because he does not bring all of his issues into them; and it protects him from becoming too dependent on these intimate personal relationships because he is able to access support outside of them. Further, PT helps Dave maintain a "sense of self", which can be achieved by maintaining these healthy boundaries within his relationships.

PT was also framed as a relationship in which one was able to discuss oneself in relation to another. Bob, who had a disability and was single and without children, had engaged in long-term therapy throughout his life, and was in therapy at the time the research interview took place. He explained how he views PT as being in-relation with someone:

> I want a relationship with somebody to explore who I am in relation to other people, cos that's what I want from it. So maybe for me it's less about

digging around what's going on in my own head and in isolation, it's more about digging around in what I feel and how I relate to other people.

Here, Bob, reveals the purpose or goals of his PT – to explore and understand his relationships with others, through the therapeutic relationship. What Bob appears to be suggesting is that the most important aspect of therapy for him is the therapeutic relationship with his therapist, and how he uses this to explore his relationships with others.

The participants' accounts of their experiences seem to suggest that therapy is a reflective space, separate from other relationships in one's life. Personal therapy provided participants with a safe and non-judgemental place, in which they felt comfortable to explore and examine their difficulties, to gain a better understanding of themselves and of their problems. Personal therapy was experienced by participants as being an intimate place, with the attention solely focused on oneself, and described as a unique relationship acting as an additional support outside family and intimate relationships. Therapy was contrasted to other relationships with colleagues and friendships which are "cluttered" with life, where one's own needs may not always take priority.

5.1.2 Subcategory 1b - Learning to identify and work with transference and countertransference

Reference was also made by participants to how they felt that PT enabled them to identify and work with the transference and countertransference phenomena arising in their clinical work. Participants explored in their PT challenges emerging as a result of the work with their clients which impacted on them personally. They learned about themselves, as well as about themselves in relationship with others through their PT, which contributed to their personal and professional growth enabling them to identify and work with the transference and countertransference.

Some participants, such as Bob and Patsy, experienced transference and countertransference for themselves within their PT post-qualification which helped them to identify and work on these issues as they arose in their clinical practice. This was considered to be a way to provide safe and ethical treatment to their clients. Patsy described using PT as a place in which to explore the transference and countertransference issues that emerged in sessions with clients, but also as place enabling her to learn about the therapeutic process:

> I think in therapy you literally use your body and your emotional world to help you to understand the other person and to understand the kind of impact they're making on you and what this means for them as well as what this might mean for you. So I think therapy offers a safe space to learn about that so we're not doing that learning with clients.

Patsy here seems to conflate her views of being a client with those of being a therapist. She views her own PT as space in which she can learn about how she relates to herself and others and how others relate to her, which is an important aspect of being a therapist too. In this sense, Patsy's view of PT represents not only a process or learning and self-awareness, but also of ethical practice.

The important, even essential role, of PT as a space to reflect upon oneself, on the issues clients bring to therapy, and how these can affect the therapist and consequently the therapeutic process, was expressed by Bob who reveals:

> As a therapist part of your job is to help facilitate that process the only way you can do that is by responding to what you're feeling, and I think that's why it's important to be in PT, because are you responding to that person's distress and upset and emotional needs or are you responding to what it triggers off in your own needs? And that is the core to why as a therapist I think you need to be in therapy.

Here, Bob also touches upon the role of PT for the continuing professional development and potentially the ethical practice of qualified counselling psychologists.

He believes that therapists should remain in therapy themselves, because a core aspect of being a therapist is their need to be aware of whether how they are feeling about and responding to their clients is grounded in the client's own experience or is brought about because it relates to one of the therapist's own issues. For Bob, PT acts as a vehicle for fostering self-awareness of himself and to understand the interplay of transference and countertransference dynamics in his therapeutic relationships.

Perhaps Bob's view of the necessity for remaining in PT is influenced by his own therapeutic orientation and work as an integrative therapist, in issues of transference and countertransference and the therapeutic relationship to be fundamental ingredients of the therapeutic work. This is in contrast to, for instance, CBT where the focus is on the changing the unhelpful cognitions and behaviours that a person may hold, and where there is less emphasis on the what can be experienced and learnt at the relational level. Consequently, the way in which Bob works therapeutically can only be performed ethically and competently if the therapist is able to identify how their own unresolved difficulties can seep into the work with clients and if unaddressed could potentially impact therapeutic practice.

Della, on the other hand, recognised the value of her in-training PT in identifying, understanding, and learning how to work with transference and countertransference during her training, but had not returned to PT post-qualification. Here, she reflects on her experience of therapy as a trainee:

> I thought it was necessary so that you could understand your countertransference mainly and to try to deal with issues you hadn't had a chance to before [...] It was through my own experience of therapy that I felt comfortable within myself to notice my reactions to my client and reflect these back to aid the therapeutic process, just as my own therapist had done with me.

Della appears to suggest that her experience of PT during training and the modelling of therapy by her therapist enabled her to learn about the countertransference

she experienced, and to identify her own reactions in therapy and use these to guide the therapeutic process with her own clients. Interestingly, despite recognising the benefit of experiential learning from her in-training PT, Della has not yet engaged in PT post-qualification. This might reveal that Della believes that her learning about, and processing of, countertransference during her training was sufficient, and that it is not necessary to use PT in this way again throughout her career spanning 30 years. Bob, on the other hand, sees transference and countertransference within his relationships with his clients as something requiring his ongoing engagement in PT and a core aspect to his being an effective therapist.

Again, this might be a reflection of the form of therapy these counselling psychologists practice. Whilst Bob and Della both reported practicing from an integrative approach, Della worked in the NHS and Bob in private practice. This indicates that Della may have been predominately practicing brief goal-orientated therapy (e.g., CBT), that is reflective of the predominant model of therapy implemented in the NHS, where less importance is placed on the relationship dynamics and the impact of the therapist on therapy. Bob, in private practice, was in a position to offer his clients and to practice longer-term therapy, where much of the attention is on the dynamics between client and therapist.

5.1.3   Subcategory 1c - Personal therapy as a self-care resource

A common theme that arose from participants' statements was that PT was an activity engaged in to resource oneself for their emotionally demanding clinical work. In this sense, PT is a form of self-care which prevents pressure and stress building to the point of burnout, and promotes wellbeing, enabling them to feel emotionally resilient. Moreover, PT was considered as a way to ensure the therapist worked on personal difficulties, hidden or shameful aspects, unconscious and repressed desires in order to

minimise the effect of these on the work with clients and to endure they continued to work in a professional manner.

Jan, who had experienced therapy following her training, expresses her view of PT as a useful resource particularly in times when she was not feeling emotionally resilient:

> Well, I think there are times when we all go through difficult things in our lives and there can be leakage emotionally or you don't feel as resilient in terms of the things you are dealing with professionally and I think it's a good idea to have therapy at those times, to make yourself a more safe practitioner.

Jan explains how engaging in PT as a professional during difficult points in her life was useful in helping her work through personal issues that, if unaddressed, could have impacted on her clinical work in unhelpful ways.

Patsy similarly referred to PT as being an activity to resource herself. She explained how she engaged in PT because she perceives it as contributing to increasing her internal resilience and "robustness", subsequently impacting on her personally and on her clinical work:

> It's ourselves that we're using and I think we need to know as much about ourselves as we can to help us be helpful to clients but also help us to manage what clients bring because sometimes it's so distressing or disturbing or unsettling. It's about giving us building in some robustness for us as well. [...] I think as a resource, I think maybe if I um...if my case load increased for example that might be one of the things that prompted me to go back into therapy.

Here, Patsy refers to the use of the self as the instrument of therapy, and recognises both the need to be self-aware and the need to care for the self, as it needs to be maintained as an effective tool within the work. Patsy, like Bob in the previous category, views it as necessary and important to manage oneself as a counselling psychologist in therapy with clients. She considers PT a vehicle to achieve "robustness" as a therapist, referring to being able to resiliently face and work with the difficult

material clients bring to therapy, similar to the resilience mentioned by Jan above. Patsy also recognises the need to practice self-care through engaging in PT might become more important when she has a higher case load. Perhaps therefore, she feels that with a lighter case load, she experiences less stress and also has time to self-reflect and engage in alternative self-care activities, therefore not requiring PT as much.

Susan also considered that therapy should be engaged in at different points in one's life, to cope with change, as she stated, "I think as a resource, I think just as a real helping hand and a resource and because we're changing our lives are changing". Here, Susan seems to be suggesting that therapy is one possible way for people generally (as opposed to counselling psychologists particularly) to cope with adjustments, change, or difficulties that arise through life. Rather than remain in therapy, therapy can be revisited as required by the individual.

Kate referred to PT as being a self-care resource for the emotionally demanding role of the therapist.

> I think that there is a sort of...well I just don't think you realise just how emotionally debilitating it is and so therefore...it's not that you're going to be a harm to your clients, or your patients. It's not that you're going to be doing them any harm or anything like that but I think it's more self-care. I think it's more your own care, so it would be therapy not so much because it's important for the well-being of your clients it's more for you. It's more for the actual therapist I think.

Here, Kate seems to view PT as a tool to enhance the therapists' own well-being, rather than as something that would be necessary in terms of protecting one's clients from the possibility of being affected by the therapist's own issues within the therapeutic relationship. Bob, Pasty and Jan hold a different view, considering PT as a tool to enable them to become more robust and resilient personally and professionally, protecting one's clients from any possible harm caused by the therapist's unaddressed difficulties. As discussed before, this may represent to some extent the nature and

orientation of the different therapies practiced by these counselling psychologists. Kate describes herself as working from an integrative/CBT perspective, which generally has less emphasis on the transference/countertransference and what the therapist beings into the therapeutic relationship. Interestingly, whilst Kate refers to clinical work as "emotionally debilitating", and views PT as a way of managing the emotional demands of the work, she had not engaged in any post-qualification PT herself across her 21 years of practice. Kate's non-engagement in PT to date might also be influenced by her view that perhaps engaging in PT for personal growth is perceived as "self-indulgent".

Engaging in PT allowed participants to explore and reflect upon their difficulties, enhancing their personal growth and strengthening their ability and confidence to work in a professional manner, consequently mitigating against unresolved issues hindering their work with clients. Even those participants who had not engaged in therapy post-qualification reported that they considered PT to be an important potential resource and a beneficial activity for counselling psychologists' self-care.

5.1.4 Subcategory 1d - Personal therapy when in crisis

Some participants engaged in PT in a time of crisis in life, rather than for general self-development and personal growth. The term "crisis" is used by participants to refer to issues such as bereavement, loss of health, loss of a job or a relationship breakdown. All these situations seemed to represent the loss of a relationship, whether this was in relation to a physical person (e.g. parents, children or a partner), or an abstract entity (e.g. job or health).

Jan disclosed that she was motivated to seek therapy following two significant life events - the loss of a relationship and the ending of a job she had been in for a long time:

It was a personal crisis after the ending of a relationship. So I wanted to achieve making some sense of that or...yeah I don't know, or being able to cope with that. And also I'd taken a secondment at a new job, away from here, which is where I've been working for 20 years. So it was two major life events going on at once both of which were quite difficult to manage...although the job was a positive thing.

Kate made a very clear distinction between "personal growth therapy" and "crisis therapy". Moreover, it was Kate's view that remaining in ongoing PT (i.e., as a form of self-development or personal growth) was "self-indulgent":

I think there is a difference between personal growth therapy and crisis therapy and I, oh gosh, this is going to sound dreadful now, but I think that there's something in it for me personally. I'm sure other people would disagree or whatever, is that I still feel that there's something self-indulgent about therapy for personal growth and I think it's probably also influenced my work really, the work that I find myself doing. I don't have so much interest I think in personal growth work as I do in crisis work and I think that that applies to me too. That I struggle, would struggle, to go and get therapy when it's just to do with growth, personal stuff...journey all of that. But like when my sister died, when there was a crisis when there was something genuinely in that time troubling then.

Here Kate explains how her view of PT is affected by the type of work she prefers to do, and does do. Making a distinction between seeking therapy for crisis versus personal growth, Kate works with clients who present themselves to therapy with a crisis, rather than seeking therapy for reasons of self-development or that might be more abstract. Kate also feels that for herself, therapy would be used to deal with personal crises, and that therapy for reasons of self-exploration and discovery of meaning are "self-indulgent". Thus, despite how "emotionally debilitating" her work can be, Kate has not yet reached a crisis point and has thus not considered it necessary to engage in PT in her two decades of practice. It might also be the case that a long career spent working with people in crisis might affect how a therapist views other

personal problems, difficulties or goals of therapy (whether their own or their clients') as 'lesser' when compared to extreme crisis.

Susan was another participant who had not been in PT post-qualification. Although she attributed this decision to the financial and time constraints of being a single mother, she did feel that a crisis might precipitate her to return to therapy. She appeared to view this as being linked to a developmental stage in life, particularly the decline in health of her elderly parents and her own ageing process. Susan seems to be saying that she would only consider engaging in PT in future for "crisis therapy" rather than "growth therapy".

Della, who had extensive experience as a counselling psychologist and had not sought PT post-training, was asked what might prompt her to seek PT in future. Like Susan, Della also disclosed that she would return to therapy in the event of something specific and unexpected occurring, such as poor health, rather than for self-reflection and personal development:

> Yes, maybe a chronic illness or something, coming to terms with maybe a terminal illness or something…I think it's very helpful at any age, I'm just saying that for myself. I know that we continue to grow but I don't think that I would just go back into therapy because it's there. I would go because of something specific.

Personal therapy seemed to represent for some participants the temporary replacement of a lost relationship, whether the loss was physical or abstract. Some participants engaged in PT predominately in a time of crisis, or would consider doing so, when motivated by a need to understand and manage one's emotional state and to provide some personal relief. Personal therapy, particularly for Kate, Della Jan and Susan seems to be a place to go to when in crisis. Interestingly, these participants also reported not finding therapy particularly helpful when it was a compulsory aspect of

their training, and that as professionals they engaged in other activities as a way to cope with work and daily life stressors.

5.2   Category 2 – 'Practice what you preach'

"Practice what you preach" has been used to label this category as an *in vivo* code (Charmaz, 2006). Although this code emerged from the account of a single participant it was also found to be expressed in some manner by almost all of the other participants. This category represents participants' self-care behaviours in seeking therapy themselves and other means of self-reflection, and consisted of two subcategories: (i) being congruent; and (ii) alternative methods for self-care.

This *in vivo* code originated in Jan's interview, in response to a question about her thoughts of activities such as holidays, religious practice, or relaxing breaks as alternative activities to PT:

> "Well I think that if you [therapist] are not prepared to practice what you preach then that says something's about you [therapist] and about how willing you are to work on yourself as a practitioner".

Jan appears to highlight the importance of the practitioner working in a way that is congruent with their beliefs (e.g., about the importance and benefits of 'working on oneself'). Jan's comment seems to relate to a perspective that it is incongruent or inauthentic of a practitioner who works therapeutically with clients to not consider therapy to be therapeutic or necessary for him or herself. Jan perhaps views herself as being congruent in her beliefs and what she espouses and engaging in PT herself is part of that process.

Personal therapy was considered by all participants to be an important tool for ongoing self-reflection and as a way of maintaining an attitude of self-awareness. The role of therapy is acknowledged as aiding a deeper understanding of one's interpersonal way of relating and in reducing the stressors of personal life and work, which

consequently impacts on the therapist's own clinical work. Alternative methods of self-care and preventing burnout that aided relaxation and relieved stress were also described, including friends, family and church, as well as holiday breaks.

5.2.1 Subcategory 2a - Being congruent

Of the eight participants, five had engaged in PT at some point post-qualification. Participants reported engaging in PT as they believed this was helpful not only for their clients but also for themselves, believing in the job they do and the service they offer. Others reported engaging in PT following qualification as a means of continual self-reflection. The idea of the alternative self-care activities used by some participants, such as a holiday or a massage, being a substitute or replacement for PT did not appear to be well-received by other participants.

Bob, who had engaged in long-term PT at different points in his life, and had disclosed how his experience of therapy had contributed to his increased self-reflective and self-awareness abilities, remarked:

> It's a resource for yourself, it seems a waste if you don't do it. If you're working with other people, who come to you for that very thing [...] and if you're committed to what you're doing, why isn't it the way? Why is it alright for other people and not you? You know I have a problem with that as well.

Joanne, who had actively sought and engaged in therapy post-qualification through several low-cost services, shared this view:

> I suppose we wouldn't be in this business would we really if we didn't believe in it as having some sort of positive value. I mean, after all if we as professionals really believe that what we do [therapy] helps, then why not engage in this ourselves from time to time when needed?

Bob views PT as a "resource" for both the clients who come to therapy and also for the therapist. He appears to find it difficult to understand why a therapist would not want to engage in PT ("why isn't it the way?"). By engaging in a process himself that

he truly believes is helpful, Bob is remaining congruent to his beliefs about therapy, and perhaps remains congruent to the philosophical basis of the therapeutic orientation from which he practices. Conversely, Bob finds it difficult to accept that some practitioners are not congruent in this way, and whilst they view therapy as something useful for others, do not engage in it for themselves. To Joanne it similarly makes sense that a practitioner who believes in the benefit or efficacy of PT would engage in it themselves. Unlike Bob, however, her view is perhaps less black-and-white as to the importance of PT for the therapist. Instead she considers PT as something to be used "from time to time when needed".

Jan, who had also engaged in PT following qualification on several occasions, reflects on the ability of professionals to explore their vulnerabilities, as clients are asked to do:

> Well, my personal belief is that if you provide something and you see it as useful and beneficial it seems natural that at points in your life you may benefit from it yourself. I don't have a position whereby I'm ok, you're not ok, you get treated. It's more that I see it as...personal development or personal growth issue that you can use from time to time [...] it's a bit of a ...you're asking your client to do something you wouldn't do yourself, if you don't do therapy. So what leg do you have to stand on to ask them to reveal to you? You don't know how it is difficult to reveal to someone the things...the thoughts you only have inside yourself that you're ashamed of, feel embarrassed about, feel you shouldn't have [...] and yet we believe as practitioners, whether CBT or otherwise, that you should be able to bring those out into the open and work with them. Well I think its hypocrisy not to be able to do that.

Jan views PT for the qualified practitioner as something "natural" to be engaged in at different points in one's career. As a practitioner she does not see herself immune from the same difficulties as her clients might experience, and questions why she too would not seek therapy for support if she ever needed it. Jan considers it hypocritical if practitioners, of any theoretical orientation, ask patients to reveal their difficulties and

embarrassing or shaming aspects of themselves, yet they are not prepared to do this themselves. She questions how practitioners are able to understand a client's perspective and experience of what one expects them to do in therapy, if they are not prepared or have not experienced PT themselves. Jan's comment seems to relate to a perspective that it is incongruent or inauthentic of a practitioner who works therapeutically with clients to not consider therapy to be therapeutic for him or herself. Jan perhaps views herself as being congruent in her beliefs and what she espouses and engaging in PT herself is part of that process.

5.2.2   Subcategory 2b - Alternative methods of self-care

Participants who had not sought PT after qualifying as a counselling psychologist mentioned various other activities they engaged in as a form of self-care and to reduce burnout.

Joanne described how, on occasions when she was unable to afford therapy, she would make use of alternative methods to relieve stress and obtain emotional support:

> I find that my contact with other colleagues can be quite therapeutic, which is good, and also meet up with a group of friends sort of friends/colleagues people I trained with and a couple of others. We meet up monthly for a sort of network support type meeting and although we don't do any therapy as such it's very supportive [...] I've got friends within this business who...it's just nice to meet up and talk and I think you get a huge relief sometimes just by talking through some things with people, to do with yourself that can possibly fill that gap a bit, that if you didn't have that.

Joanne says that talking to other colleagues and friends who are themselves in the "business" of therapy is something she finds resourceful, especially in times perhaps when unable to afford PT. Rather than being something that she uses on an ad-hoc, Joanne has some structure around this additional or alternative self-care activity, because the meetings take place on a monthly basis. Joanne experiences a "huge relief" unburdening herself in this quasi-professional setting. Joanne's except here points to

how engaging in regular alternative self-care activities such as professional networking, meet-ups, or peer supervision, can support a qualified counselling psychologist in managing the demands of their job.

Kate had not engaged in therapy post-qualification but described alternative methods of self-care, which reflected relaxing, or soothing types of activity:

> Maybe go and have a lovely massage (laughs) or something. Even like go to a mindfulness retreat or things that are rather more soothing [...] if I begin to feel a bit sort of down physically or whatever as I said I'd rather spend that money, you know, go off and have a week in Tunisia with and pay for all other people to come with me.

Kate had felt uncomfortable talking about and revealing aspects of herself in PT during her training, but was able to use other self-renewal activities if she "felt down" or physically tried. As these activities were directed towards disengaging from stress, they perhaps are less inclined to induce self-reflection and self-awareness as PT might. However, the practice of mindfulness that Kate refers to, is currently being integrated with CBT (MB-CBT), and demonstrates some efficacy in the treatment of depression. Consequently, engaging in mindfulness or other meditative practices could also be viewed as psychotherapeutic activities, rather than non-therapy activities.

Like Kate, Della's PT during her training had not been a particularly pleasant experience. As a qualified professional, Della used family, friends, attending church, and prayer as alternative methods to deal with difficulties in life, stating, "I don't need to go to therapy. If something's wrong, I could find other ways first". For Della, it seems that she views therapy as something that might be used only if other sources of self-care or support were not present, which for herself is not an issue as she has multiple ways of seeking help for her problems or difficulties.

This second major category 'practice what you preach' relates to some participants' view that it is congruent to engage in PT – whether regularly or as needed

– because the practitioner is being more authentic regarding their beliefs about the value and benefit of therapy they are offering their clients. If a practitioner does not use therapy to deal with issues or develop self-awareness, or is not prepared to experience what they expect their clients to experience then it is possible that this will affect their practice and their work with clients. When private therapy was considered to be too costly, but nevertheless was felt to be necessary, some practitioners accessed therapy provided by no-cost or low-cost organisations such as the NHS and the charity MIND. Other participants including those who had negative experiences of PT during their training, and others who could not always afford PT, engaged in non-therapy forms of self-care – viewed as appropriate alternatives to PT – once they were qualified, to help them manage stress and create a space for personal reflection. Activities such as speaking to a colleague or a friend, including in structured regular meetings, were viewed as beneficial ways of alleviating distress and enabling one to 'offload' the stresses of work or personal issues. Further self-care activities included going on holiday, attending church, and prayer - which were also considered to be preferred ways of coping with stress, exhaustion, or life difficulties by the participants who used them. Indeed, in terms of managing work-related stress and life stress in general, many of these activities are recommended by therapists to their clients as things that they could try outside of the therapy.

5.3   Category 3 - The 'Ideal Therapist'

The major category "the ideal therapist" was constructed to encompass both the views of participants who had alluded to the need to portray an invulnerable professional self to their clients and colleagues, as well as those who discussed issues with finding a good-fit therapist for themselves.

5.3.1 Subcategory 3a - Not showing vulnerability

From some participants' accounts it appeared that there was an expectation to be an ideal therapist. These expectations were viewed as arising from both external sources, such as working in an expensive private practice environment, as well as internal self-generated expectations and demands of the participants themselves on how they should conduct themselves professionally. Personal therapy was perceived as something one engages in when unable to cope with difficulties oneself using one's own strengths and resources. Perhaps some professional practitioners hold a belief that by engaging in PT they are somehow revealing themselves to be less ideal, less perfect, and less professional than a practitioner who does not seek therapy.

Kate, who had worked as a consultant counselling psychologist in a wealthy private practice, described feeling a sense of embarrassment of seeking therapy at a time of difficulty in her life:

> I think it was probably because the environment that I was working in was a private high-powered environment and even though, it's ridiculous really because they were very supportive of me, I at the time didn't feel that I could sort of be...what's the word... less than 100%, pretty much, in such a high-powered environment, very busy environment.

It is not clear in Kate's account, whether her embarrassment was regarding her workplace knowing that she was seeking therapy, or whether she could have addressed this issue by seeking therapy privately without her workplace knowing. However, although she described her work environment as "high-powered" she also stated that they "were very supportive". This indicates that the expectation to be no less than 100% (and consequently the feeling of embarrassment regarding seeking therapy) was perhaps more influenced by Kate's internalised or perfectionist demands that she placed on herself rather than this being due the expectation placed upon her by others. If counselling psychologists hold beliefs or concerns regarding themselves as being (or

appearing) in some way flawed and 'less than ideal' by seeking therapy, they are more likely to avoid seeking therapy. Similarly, they might also be less likely to seek other forms of support or ask others for help. This perhaps reflects a wider view in society of the stigma surrounding psychological therapies that can prevent people from seeking professional help.

Other participants, despite having engaged in PT as a qualified professional, also acknowledged an element of embarrassment or possibly shame present amongst professionals in the workplace.

Jan reflects on elements of shame that may be present in a wider context, amongst professionals in the field of counselling psychology.

> We're no different to the people we see, you know, shit happens and it's how we deal with it that matters and not the shame for the fact that it happened. I just think then that the whole system has a shame element to it [...] as professionals in the field, we promote therapy, otherwise we are in the wrong profession, yet when we [counselling psychologists] may benefit from therapy we have a different attitude.

Here, Jan doesn't seem to be saying she feels shame herself, but that she recognises that others in the field might do so. Jan refers again to the notion of congruence here, pointing out that whilst professionals in the field promote therapy for others, they appear to have a different attitude about seeking therapy for themselves, which might in part be rooted in her view that the "whole system has a shame element to it".

Elements of the potential embarrassment or shame experienced by mental health professionals when seeking therapy were also reported implicitly by Dave, who worked in an affluent area in the city:

> You know I can only respect and admire people going for therapy, especially other professionals because I think that sometimes I think there's a

sense of you know false pride that gets in the way of people...other therapists accessing therapy.

Dave recognises the difficulty in accepting and seeking therapy for any person, especially other professionals in the field and describes his respect and admiration for people who are able to take this step. He describes a sense of "false pride" among some practitioners. Here perhaps, he is referring to some practitioners' need to be seen as knowledgeable, skilful and competent by others – including any therapist who they might otherwise seek help from. False pride might therefore prevent some counselling psychologists from accessing therapy because they would not want to be seen to need help, or want to receive help from another professional.

The notion of false pride links to the main category and the view of the 'ideal therapist', where the professional practitioner feels (from internalised demands) the need to portray him or herself at all times as competent and "100%" perfect. False pride in this sense could be conceptualised as a defence mechanism whereby professionals come to convince themselves that they can (or should be able to) manage their emotions, difficulties, work-related stress and demands, even the transference and countertransference with their clients, without outside help or a 'fresh pair of therapeutic eyes'.

Bob, who had been in long-term therapy at different points in his life, further revealed a collective devaluation of therapy from some professionals in his previous workplace:

> I worked in a clinic in an affluent area with psychiatrists and doctors who really didn't have any therapy. And I would not say there is a negative view of therapy, but you know there is a kind of... why bother with it?

Bob's comments here seem to infer that some mental health professionals who offer or refer patients into therapy do not recognise the value of therapy for themselves. Perhaps Bob's experience reflects the fact that professionals with a medical training and

background (such as the doctors and psychiatrists in his clinic) align more to a medical model and value the medical treatment of difficulties, and take the psychosocial aspect of treatment less seriously. Nevertheless, without knowing what the attitude towards PT is of other psychologists within Bob's clinic, it seems likely that some of the attitudes prevalent amongst medical professionals could cascade throughout an organisation affecting the attitudes and beliefs of others.

Some participants' accounts suggest that there is a belief that arises from within oneself that working as a qualified counselling psychologist equates with being perceived as professional, competent and knowledgeable at all times - reflecting the notion of the "ideal therapist". Appearing without any vulnerability seemed to derive both from within oneself (e.g., self-criticism, false pride) and from real or perceived external influences (e.g., colleagues, workplace expectations). One consequence of this might be a reluctance to seek emotional support such as PT, or feelings of shame or embarrassment admitting to having difficulties or being in therapy.

5.3.2   Subcategory 3b - Seeking a good-fit therapist

When searching for a therapist, some participants considered it essential that any potential therapist was competent in their practice and use of therapeutic skills, which was linked to their training and years of clinical experience. Others felt it was more important that their therapist possessed other qualities such as an awareness and understanding of difference and experiences of being different, such as ethnicity or (dis)ability, or a shared belief system.

With many years of experience herself, Kate felt that the most critical aspect of selecting a potential therapist would be their competency. She considered that searching for a therapist could be a challenging task, particularly as she relates this to the lack of competency she witnessed in previous colleagues:

I'm just realising that is a huge thing for me is competency in others [...] its competency and that's a big thing I think. That's a big thing for me really. I would find it (laughs) I would probably find it quite difficult to find somebody, actually as I'm saying it probably where I was, at this other big place, there weren't many people who I would have really felt were competent anyway, actually in a way.

When she was asked what she would look for in a potential therapist, Kate replied, "now, it would be a big selection process yes...because of my experience and everything obviously one becomes quite fussy". With first-hand experience of working alongside practitioners who she believes were not competent to practice, Kate seems to recognise that finding one who is competent and knowledgeable, according to her standards, might be difficult.

Joanne further discloses how the length of clinical experience and formal training are two very important aspects she considers when searching for a therapist.

It's surprisingly difficult to search and find a therapist that I feel I can work with, possibly because as a professional I'm more aware of what I want and what I am looking for. But I do think that perhaps I consider the training they [the therapist] has done and the amount of clinical practice as crucial aspects when searching for a therapist.

What seems to transpire from Joanne's account is that, as a professional, one may be more aware of one's preferences and needs of therapy, and is therefore more informed about what to look for and what to ask when seeking a therapist. As Joanne states, this sense of being informed can be a positive factor, but can also be an inhibiting factor because of the number of factors they are taking into account and judgements they might be making when searching for a therapist. In fact, with so many criteria to use when selecting the "ideal" therapist, Joanne, like Kate, considers it would be "difficult" to make a decision on a therapist for their own PT.

For Bob, who presented with a disability, and Patsy, who is from an ethnic minority group, the search for a therapist with knowledge of difference was considered a very important aspect. As Bob says:

Well one of the (pause) because I have a disability (pause) one of the issues, it's probably like for someone who's black or from an ethnic minority, you're looking for somebody who is able to deal with that in an honest way and that's quite difficult to spot on the initial session anyway. I would look for somebody who had some understanding of that.

Patsy, an Asian woman, seems to express that when searching for a therapist she looks for someone who in some way matches her life experiences, especially of feeling like an outsider in country different from one's ethnic and cultural background:

I think because I'm a British born Asian female so I kind of wanted...what I was aware of was when I sought out therapists I kind of wanted therapists that had an awareness of difference. That one of the questions I would ask them about...about being different but also kind of that experience of having lived somewhere lived in a country where maybe you aren't entirely accepted just for being there.

Della spoke about the importance of her faith in her life and how she felt that may impact her finding a therapist, as she would actively seek a therapist who shared her Christian beliefs:

It would have to be someone who believes in the things that I do. Because now, obviously I don't impose it on people unless they bring it up, I just feel that it is something missing and I'm convinced there's something missing in their lives and I can't do anything about it so I don't want to put myself in that position. You can't talk about it with someone who's not a Christian as a therapist because that's not their paradigm, you know.

Della here seems to say that she would not be able to work effectively (as a client) with a therapist who is not a Christian and who does not share her belief system. Although she stresses that she doesn't "impose" her beliefs on others "unless they bring

it up" she does believe that non-Christians have "something missing". In terms of any PT she would seek, and because her faith is important to her, Della would require a therapist to be a Christian. Thus, it could be said that Della is congruent with her own beliefs and would want to work in therapy only with another practitioner who also shared those beliefs. However, as it is anticipated that several if not many of her own clients will have different spiritual beliefs to hers, or may have no spiritual beliefs at all, it could also be argued that Della is not being congruent in her work with such clients, as she cannot "do anything about" her view that non-Christians have something missing.

The category the 'ideal therapist' encompassed two subcategories; not showing vulnerability and seeking a good-fit therapist. Some of the participants' accounts seem to suggest that there is a view held by some counselling psychologists that having difficulties that require them to engage in PT makes them judge themselves or believe they are being judged by others as somehow less ideal, less perfect, and a less competent practitioner than those who do not need to seek therapy. Jan refers to professionals promoting therapy for others as beneficial yet holding a different attitude when seeking therapy for themselves. This leads to the idea of 'congruence', or incongruence, where therapists believe therapy is helpful to people generally but are perhaps more resistant or reluctant to believe this could be of any help to them. The notion of false pride presented by Dave describes how some counselling psychologists might struggle with seeking therapy because it places them in a position of knowing less than another practitioner. Both these attitudes may be a way to defend against hidden shame and feeling of incompetence as a professional. Once participants were qualified and with several years of clinical experience, the selection of a therapist was more detailed and based on different important criteria, including professional competence, training, and a shared belief system. The fact that qualified and experienced counselling

psychologists have more information and opinions about what makes a good therapist and know how to evaluate potential therapists, can actually make it more difficult for them to find an ("ideal") therapist who matches all their criteria.

5.4 Category 4 - Compliance and Confusion of Compulsory Personal Therapy as Trainees

This theme relates to how mandatory PT during training was perceived, experienced and understood during training by the participants when they themselves were trainees. This major category includes two subcategories: a lack of emphasis and confusion of personal therapy as trainees and ambivalence towards personal therapy as trainees.

5.4.1 Subcategory 4a - Lack of emphasis and confusion of personal therapy as trainees

The view that PT was not sufficiently integrated into their training programmes was raised by several of the participants. They recalled that during their training there was a lack of discussion with colleagues and tutors about the role of PT, and that limited or no support was provided in seeking a therapist.

Dave reflected on his experience of PT as a trainee being rather confusing, with very little advice and guidance provided by course tutors:

> You know, I suppose I was quite naïve, I kind of assumed that you know all therapists could do a good job. Um and you know never really thought about what am I getting out of this?...Um and is this helping?[...] I didn't feel that we got enough instruction and advice around seeking personal therapy as a counselling psychologist. I think the message was that you [trainee] need to know.

Dave highlights the difficulty for himself as a trainee first seeking therapy, in knowing how to select a therapist, how to decide whether a therapist and their orientation is appropriate, and how to evaluate the therapy and progress made within it. Dave discloses how uncertain and confusing it was to be in therapy when not knowing

what questions to ask, how to monitor any progress and whether he was experiencing any benefits. He also expresses how there appeared to be little or no guidance on engagement in PT from his training, and how and at times he considered he was being told that he was responsible for his own PT.

Dave also felt that, because of the uncertainty and lack of clarity on what to expect from therapy, one of his first experiences of therapy was unhelpful:

> I supposed some of that from the university in my training, where I trained it would have been really helpful in terms of certain questions to keep in mind and I think as a result of that lack of information I kind of stuck with someone and now I look back and go what the hell was I doing sticking with this person?

Here Dave talks about not knowing what kind of questions to ask, or "keep in mind" whilst in therapy. Not knowing what to expect, ask, or question, resulted in him persevering with who he now considers to have been an unsuitable therapist and, in hindsight, he thinks that he should have terminated the therapy sooner. Dave's experience of not knowing how to select a therapist during his training resulted in him perhaps selecting an inappropriate one. This contrasts with the views of qualified counselling psychologists with several years' experience, such as Kate, Patsy and Della, who recognise the difficulty in choosing a therapist at all because of what they now know about therapy.

Bob describes how the overall financial burden of training as a counselling psychologist can mean that trainees' relegate their PT to a lesser status of importance in the training process.

> Counselling or therapy are not costed into the price of the course so people don't quite realise the full cost of what it is to do a doctorate [...] not only the time, the loss of income that you can't work, the pressure to do lots of placements which are usually and almost exclusively unpaid, and pay for your therapy. And I think therapy gets pushed a little bit, so they did their 40 hours

and try to get them out of the way, and I think it should really be central to what you're doing as a counselling psychologist.

This points to two ways in which PT can be disconnected from the process of training. First, perhaps the institutions that manage the training of counselling psychologists do not emphasise the importance or purpose of PT enough, or set more realistic expectations about the 'hidden' costs of training. Second, although Bob views PT as central to the training and profession of counselling psychology, he relates the scenario whereby trainees are eager to complete or "get out the way" their required number of therapy hours, to minimise the expense of engaging in therapy. Thus, therapy is seen as one of many course requirements and a financial burden rather than something that is given adequate attention by trainees during their training.

Patsy highlighted this also in her account of her experience of PT during training as "a box-ticking exercise". She felt that her PT did not feel like "an integral part of the training" and was not "woven in enough" to the training process. This again illustrates perhaps how institutions do not make it clear to trainees what the role of their PT during training is, and instruct them on how to make sense of their PT within the broader context of their university studies, and their supervised practice.

Della made reference to her experience of therapy as a trainee, recalling it as a confusing and unpleasant experience:

> I remember when I was training...I had a therapist who was, to say the least, very removed emotionally. She was psychoanalytically trained, and I knew I had to do my 200 or so hours to get through the course. I think now why I did not change? But, I guess at the time I was looking for a psychoanalyst and probably thought that's how they are.

Like Bob, Della now questions the logic of remaining with a therapist who she did not feel was emotionally present in the relationship. Also, being a trainee, she was not sure what to expect, or how to evaluate the therapy she was receiving, and assumed

that her discomfort at the therapist's emotionally detached stance was integral to a psychoanalytically oriented form of therapy. Della also reflects on the fact that any decision to end or change therapist at the time was influenced by the requirement to fulfil a certain number of therapy hours. Della was one of the participants who had not sought PT post-qualification, and perhaps the 200 hours of unpleasant therapy she experienced during training influenced her expectations of therapy generally.

Some participants had engaged in PT prior to starting their training in counselling psychology, and were consequently better informed about the experience of PT. Others had no prior knowledge of therapy and had never experienced or observed any. Participants' accounts suggest that the lack of knowledge and information about therapy during training contributed to their experience of therapy as a confusing process. This consequently led them to not fully engage in the therapeutic process, finding therapy an emotionally and financially burdensome activity and a negative addition to the academic and clinical work.

5.4.2 Subcategory 4b - Ambivalence towards personal therapy as trainees

Some participants reported that, as trainees, they were ambivalent about PT. They felt that this was partly due to their lack of knowledge about therapy and not having understood its importance, but also because of not wanting to be too emotionally exposed.

Kate expressed ambivalence towards engaging in therapy, viewing it as a challenging process and one to be avoided if possible. She revealed how, as a trainee, exploring her emotions in therapy felt like a difficult addition to the course:

> When I was training, you're kind of concentrating a lot actually on the training and on the academic work and also on your placements and all sorts of things that I don't think really... you have to have therapy but you don't necessarily want to be challenged in your therapy because it would be too much [...] um but I think from a personal point of view I think that because I was so busy doing the course and doing all the work really engaging in the personal

therapy, as maybe you should have done, was rather secondary. So I was kind of doing it because you had to. But I wasn't necessarily thinking aha, you know, this is a great personal journey this is a great personal growth experience.

Kate again touches upon the need to 'tick boxes' through attending PT (even if not fully engaging in the process), and that therapy was placed secondary to the academic and applied components of the course. This represents again the notion of a lack of emphasis by institutions, and lack of understanding by trainees, on the role of PT as an important aspect of professional training.

Patsy described how she felt unable to accept mandatory therapy during her training, and did not appreciate its value:

I kind of resented it. I didn't really understand...I could kind of cognitively see a value in it but I didn't really experience a value in it because I don't think I...I thought it was a requirement like getting a placement. It was kind of academic, you know? [...] so at first I felt like, what is the point really? And to be honest I probably at the start felt I was not going to gain anything from it.

Although logically recognising that there could be a value to PT during training, Patsy did not experience that value at a personal level, and admits that even going into therapy she was not expecting to gain anything from it. Patsy considers the PT as "kind of academic" - an additional activity or assignment as part of the course - rather than as a way of experientially learning and developing her competence as a counselling psychologist. This again highlights a potential issue with training bodies or institutions that have not helped trainees to understand the purpose of their PT, and make connections between what they are experiencing and observing in their own therapy, and what they are learning about and practicing with in their placements.

Susan experienced PT as something that she needed to "fit in" around everything else in her life, professionally and personally. Because her therapy was part of her

training requirement, she felt that her use of therapy was not linked to whether she needed therapy at that time:

> So as well as trying to get a place in a placement, as well as paying for your own supervision, as well as working, raising a family, going to college, submitting work you had to fit in, to me it often felt I was fitting in personal therapy and sometimes it wasn't necessarily matching when I might have needed it.

Participants appeared to suggest that due to the lack of emphasis on PT during their training, and to the various stresses associated with training and life generally, they developed an ambivalent and at times a resentful attitude towards PT. Many did not enjoy the experience but merely tolerated it as one of many course requirements, and consequently seemed to be more focused on the outcome (completing the required hours) than the process. Therapy became associated with a burdensome activity that needed to be 'slotted' into one's week as a way to get past the course requirements.

5.5 Category 5 - Approval, Ambivalence and Constraints of Personal Therapy as Post-Qualification CPD

This category reflects participants' views of therapy as having a possible place as a CPD activity and included two subcategories: favouring personal therapy as part of CPD, and the uncertainty of personal therapy as part of CPD.

5.5.1 Subcategory 5a - Favouring personal therapy as part of CPD

Participants' accounts suggested that most consider PT to be a useful resource, with many supporting its inclusion as a voluntary CPD activity, despite not all of them having engaged themselves in PT themselves post-qualification. In fact, several of the interviewees seemed in favour of the possibility of PT being a compulsory CPD activity to provide continuous self-development for the professional practitioner. One participant (Della) was clearly not in favour of PT as a compulsory CPD activity and a further view proposed was that, as a counselling psychology practitioner, one perhaps

could choose to engage in PT at different stages in one's career as a self-reflective activity.

Kate was in favour of including PT as a self-reflective CPD activity, and proposed setting a minimum of ten to fifteen hours of therapy every five years or so:

I think it's probably something that should be...maybe it should even be part of CPD maybe it should be something that, you know, you actually do...maybe there should be a number of hours maybe that you do minimally of personal therapy every...I don't know every 5 years or something [...] maybe there should be something about every 5 years...maybe every 5 years or something you should do 10 hours of personal therapy rather than doing the usual continuing professional development. Maybe that would be something.

Similarly, Susan approved of engaging in PT at different points in life as a way to resource herself from work and personal difficulties:

Just in terms of your personal resources, when you get difficulties...we all have a life outside of our work. We are expected to sit with people and be very containing and be therapeutic...and so in exactly the same reasons why I think it's useful during training I think it's useful in an ongoing way. If you're experiencing personal difficulties, or just even in terms of the caseload the things that step outside of supervision and impact on other people...

Here, Susan points out that the benefits and purpose of engaging in PT during training continue post-qualification, specifically the need to engage in therapy to be able to manage one's therapeutic relationships in a way that is beneficial to one's clients. She also mentions here her view that supervision alone might not cover all of the issues a therapist can face in her work. She sees PT as a space where one can explore and work on personal difficulties as well as professional challenges, perhaps relating to the impact of the client's difficulties on the therapist in therapy and in relationships they have with others.

Joanne was also in favour of engaging in therapy post-qualification, as a way of maintaining continuous self-awareness, possibly even gaining more from the experience once qualified:

> I think it's important, because I think we are challenged a lot actually and I think although you are qualified I think it's really important that you still look at your own continuous professional development and that is going to involve things that come up for you, perhaps with clients or within your own life and so...I don't think it's just a question of just saying, you know, you have personal therapy while you're training and that's it you don't need it cos I think actually, urm, in some ways I think you can get more from it actually when you qualify [...] yeah I just think how you change as a person as well, you know, you develop and you change as time goes on so you know therefore you probably would find it beneficial at different times of your life.

Joanne here seems to be in favour of PT for the qualified counselling psychologist, as an activity for CPD. She considers PT for the qualified practitioner a way to continue to reflect and work on difficulties arsing from one's personal life, but also from the stories that clients bring to therapy. Joanne felt that she has gained more from her own PT since she qualified, probably because currently therapy is now optional and based upon real needs and openness to follow the process, rather than a compulsory activity.

The view of PT as an activity to be engaged in throughout one's life as a practitioner, and a possible CPD activity, was also supported by Jan:

> I think that if you don't continue to be open and curious about yourself and about other people and anything that contributes to that I think is useful. It enabled me to feel much safer as a practitioner that I had my boundaries around my own feelings....we're meant to be reflective, self reflective practitioners aren't we, both in terms of theory and practice, and if you don't...if there's a lot going on in your own life you need to check out continuously throughout your life.

Jan describes PT as helping her become more self-aware and curious about herself as a person, but also as providing a boundary around her feelings enabling her to be a "much safer" practitioner. Personal therapy seems to enable Jan to work safely and professionally as a practitioner, because she can manage and contain her feelings, especially those that are likely to impact upon her work with clients or undermine the therapeutic relationship. Jan's view is that the qualified counselling psychologist is required to be self-reflective not simply in theory but also in practice, and that the practitioner needs to continuously check with themselves if the therapeutic service they are offering to clients is safe and professional.

Although he was personally in favour of remaining in PT post-qualification, and had done so, Bob also acknowledged that engagement with PT does vary with the therapists' theoretical orientation. His suggestion was that newly qualified professionals should be required to engage in PT a year following attaining a professional qualification.

> So that depends on slightly on the orientation of the individual. But I think it's important that everybody has it and I think that it should be continuous during...certainly during your training. But actually I would think a year after when you're in practice.

Here Bob makes the point that different therapeutic orientations place different emphasis on issues such as the centrality of the role of the therapeutic relationship, transference and countertransference, unconscious processes, or the role of the therapist within the therapy. Consequently depending on the model and assumptions of the therapy used by a practitioner, PT is likely to be more or less important. Bob works in an integrative and psychodynamic way and offers longer-term therapy, so for him it has been important to remain engaged in PT.

Some participants believed that PT engaged in post-qualification could allow for greater learning to take place, as the demands of training are no longer present, one has

a clearer idea of what to expect from the therapeutic process, and presents for therapy with genuine issues or goals. Engaging in PT as a professional practitioner was described as a space that was different to therapy during training, allowing for deeper self-exploration and greater freedom in what to explore and focus on. Participants viewed PT as a tool to maintain reflective practice, as a way to ensure working with clients in a safe and professional manner. Although not all participants in the study felt able to afford therapy, those who were determined to pursue therapy had received therapy at no cost or at low-cost through private and public organisations.

5.5.2 Subcategory 5b - The uncertainty of personal therapy as part of CPD

Participants who had not engaged in PT post-qualification nevertheless contemplated the idea of PT being a compulsory activity for CPD. Della, who was not against the idea of PT as an optional part of CPD, expressed concerns about the financial cost of PT, and proposed free alternative methods of support, such as family, friends, colleagues and faith. When she was asked why she had not sought therapy herself, and whether this was due to financial reasons, Della replied:

> I've got an extremely good supervisor, so it's not personal, it's professional issues really now, for me. I'm not being arrogant about that, I mean I've been around the block a few times, if you'd asked me this 10 years ago I probably would have had a different perspective on it..

Della did have many years of clinical experience and expressed feeling able to work on her personal difficulties without engaging in therapy, or is perhaps expressing the idea that she has already worked through her personal issues having "been round the block a few times". Because the remaining issues Della needs to address are professional, rather than personal, she considers that her supervisory relationship adequately meets her needs. As discussed before, Della also made use of church, her family and friends and colleagues, as a way of making sure she was addressing any

difficulties or stressors in her life, and felt that these activities prevented the need for her seeking PT.

Although not against PT as part of CPD, and recognising its potential value post-qualification, Susan disclosed feeling unable to prioritise it at this time in her life, emphasising the financial burden of the cost of therapy:

> I think it's useful during training I think it's useful in an ongoing way [...] however at present, financial constraints come into play there for me. I mean, personally for me. I'm a single parent, I've got a massive mortgage, I live in West London...so, you know my money is gone. So, I don't see it as an indulgence, but certainly something which could not take on top of the pile...couldn't be on top of the pile in terms of spending.

Jan, who had engaged in PT post-qualification, expressed uncertainty about therapy being included as a compulsory activity for CPD.

> I think theory and experience should come together and meet somewhere in the middle, so I do think it's essential...and I think we're underdeveloped as a professional body, and we need to develop ourselves, and personal therapy is just a part of that, as a foundation stone I see it. As to whether you need to do it for continuing, I don't know. I think that if you don't continue to be open and curious about yourself and about other people and anything that contributes to that I think is useful.

Jan considers it important that counselling psychologists remain "open and curious" and that therapy can contribute to fostering this attitude in practitioners as it encourages them to be inquisitive and self-reflective. Whilst being unsure about the need for compulsory PT post-qualification, Jan refers to PT as a "foundation stone" for the development of practitioners, although this view of the importance of PT was not understood by many of the participants during their training.

Patsy, who had engaged in PT post-qualification and expressed learning a great deal from her experience, about herself personally and in relation to her clinical work

therapeutic process, was less certain about PT being a compulsory activity as part of CPD.

> I think that having therapy as a mandatory part of training is important for the trainee's development into becoming a professional, also because there is a risk that if this was not [mandatory] trainees may not choose to do it. But I think that for the professional, well one would hope that they are self-aware enough to recognise when they are experiencing difficulties and that perhaps going back into therapy may be beneficial. Making it [personal therapy] compulsory would perhaps make it feel burdensome, whereas if this is optional one feels less constrained and able to make use of this more freely.

Patsy considers PT needs to be compulsory during training because whilst it is viewed by Patsy as an important part of training (although again, this importance was not understood by all participants at the time of their training), it is likely that many trainees would not engage in the process if it was only optional. Patsy considers that professional counselling psychologists should be trusted to seek PT if they consider it would be beneficial for them, and to engage it in as a non-compulsory activity. The mandatory nature of PT for the professional is suggested to take away the freedom of deciding if, when and why to engage in PT, making it feel like an obligation rather than a useful exploratory activity.

Although most participants reported PT as a useful activity contributing to their personal and professional development, their views of therapy being included as a mandatory requirement for CPD were divided. Some were in favour of PT being included as an optional and possibly mandatory activity for CPD, and were in support of this as a way to maintain personal and professional development as a therapist. Others felt less certain about therapy being a requirement of CPD, mostly because of time and financial constraints. It was also considered important to trust professionals to decide when to seek therapy themselves, rather than force them to do so. Some participants, who had not engaged in therapy post-training seemed more ambivalent of its role in

CPD, but were not entirely opposed to the idea and could appreciate some of the benefits therapy entailed.

5.6 Construction of the Theoretical Framework: Diverging Attitudes Towards the Role of Post-Qualification Personal Therapy

The last phase of analysis involved integrating and understanding the constructed categories and their relationships, with the ultimate aim of constructing an initial theoretical framework that is grounded in the emerging data, which has been socially constructed by the researcher and participants (Charmaz, 2006; Charmaz & Henwood, 2008; Henwood & Pidgeon, 2003). The grounded theory *diverging attitudes towards the role of post-qualification personal therapy* was constructed following an extended period of engagement with the data. The core category was considered to provide an overall understanding of how PT is considered, used, viewed and experienced by qualified counselling psychologists. Figure 2 aims to capture the role of post-qualification PT for counselling psychologists, and how the main categories form the constructed theoretical framework.

The core category was thought to provide a preliminary explanatory process of how qualified counselling psychologists view, experience, understand and make use of PT post-qualification, and thus offer a tentative initial model. Divergence was expressed, to some degree, in all of the five major categories, and it was considered by the researcher (and after consultation with the research supervisor) to provide a tentative answer to the overall research question of how qualified counselling psychologists view, experience and understand the role of PT post-qualification.

5.7 Summary of Findings

Whilst several participants described using PT for personal reasons, personal development and self-awareness, other participants engaged in therapy as a way to overcome a crisis in life. Personal therapy was regarded as a unique space where the

focus was solely on oneself and one's needs, and where there is no obligation to take into consideration the feelings, judgements or wishes or others. For some participants, PT was also engaged in as a form of professional development, to ensure continual self-awareness of one's abilities, awareness of limits and level of competence.

Divergence in views was found with some participants engaging in PT post-qualification, considering this to be related to being congruent as a therapist and believing that the work one does with clients could also be beneficial to the self, with others holding a different view. When private therapy was considered to be too costly, but it was felt to be necessary, low-cost therapy was accessed for example through charity organisations. Other participants who had reported negative experiences of PT during their training preferred to engage different self-care activities once they were qualified, to help them cope with stress, take time to relax, and to create a space for personal reflection.

Divergence in attitudes was also reflected with regards to what qualified therapists looked for when they themselves wished to engage in PT. Some considered that they were now more selective or clear in what they were looking for in a potential therapy, due to professional competence, training and personal experience. Conversely, other participants felt that it could be a challenge to find a therapist who matched their criteria, due to their increased knowledge of PT and the practice of counselling psychology. Some of the participants' accounts seem to suggest that if a professional practitioner engages in PT it implies that they are somehow less ideal, less perfect, and a less professional practitioner than one who does not require or seek therapy. The notion of "false pride" as described by one participant, might explain why some counselling psychologists could be reluctant to seek help as it would make them appear to be less competent than the therapist who was providing them with therapy. Participants considered that with experience and knowledge of therapy they were now more

selective or clear in what they were looking for in a potential therapy – basing this decision on factors such as professional competence, training, congruence with their own belief system, or understanding of difference and experience of difference. Conversely, some participants felt that it could be difficult to select a therapist because, knowing as much as they now do about the practice of counselling psychology, it would be a challenge to find a therapist who matched their criteria for an ideal therapist.

Divergent attitudes towards PT were also reflected in the unexpected finding relating to PT during training. Whilst PT is an integral part of counselling psychology training, many participants did not feel a connection between PT in their training and what they were learning. There was an overall consensus from participants that the mandatory PT they participated in during their training had been experienced by themselves or others as a costly or unpleasant experience that was viewed as a burden or treated as an 'assignment' to be completed, rather than a process which could teach them experientially about the things they were learning and applying elsewhere on their course. Some participants did recognise the benefit of their mandatory PT however, whether to experience the client's perspective, to learn how 'not to work' with their own clients, or to process countertransference that had arisen with clients during their training. This unforeseen finding, of past negative experiences of PT during training, is likely to contribute to the shaping of attitudes, expectancies, intentions, and actual engagement in, PT post-qualification.

Finally, a divergence in attitudes towards PT was found in views of PT as a potential post-qualification CPD activity. Although PT was reported as a useful activity contributing to personal and professional development, views of therapy being included as a mandatory requirement for CPD were divided. Some participants described engaging in PT to continually develop and enhance their knowledge and skills as a practitioner and were in favour of PT being included as an optional and possibly

mandatory activity for CPD, as a way to maintain professional development, competency and skills and to ensure safe and effective practice. Others were less certain about therapy being a requirement of CPD, mostly because of time and financial constraints. A further view was that it is important to trust professionals to decide when and if to seek therapy themselves, rather than force them to do so, which can undermine the therapy experience and the benefits that can arise from engagement with voluntary therapy.

6. DISCUSSION

Personal therapy (PT) is an integral part of training in counselling psychology and it is considered to play a vital role in fostering a self-reflective and self-aware attitude and playing an essential role for the development of self-awareness, reflective practice, and a better understanding of personal and interpersonal dynamics and how these unfold in therapy. Nevertheless, whilst PT is considered to be an essential aspect of training, it is not currently included as a CPD activity within the HCPC (2012) for qualified counselling psychologists. These CPD activities outlined by the HCPC are designed to ensure that professionals continue to be able to practise safely, effectively, and legally, within their changing scope of practice. As PT is viewed as an important (and therefore compulsory aspect of training), so too might it provide one means of maintaining professional standards, coping with professional and work-related issues, and ensuring safe and effective practice for qualified psychologists.

6.1   Overview

The present study sought to explore the processes which might influence counselling psychologists to engage (or not) in PT post-qualification (i.e., once PT is no longer compulsory), and to understand more about how counselling psychologists view PT as contributing to their professional and personal development. It was also hoped to understand how qualified counselling psychologists viewed the possibility or potential for PT as a CPD activity, and that the findings of the study would provide some insight into how and why counselling psychologists use PT once they are qualified, and potentially open a debate about the potential role of PT as an ongoing (voluntary or compulsory) activity for qualified counselling psychologists.

This chapter provides a discussion about the findings of the grounded theory analysis, which are reflected upon within the context of current research. The contribution of the study and the potential implications of the finding for the profession

of counselling psychology, both in the training of counselling psychologists and their ongoing professional development, are also discussed. The limitations of this study are also outlined, along with recommendations for future research. The chapter concludes with a reflexive summary of the researcher's experience of conducting the study.

6.2   Summary of the Results

The following section includes the exploration of the five major categories and their encompassing subcategories, in the context of existing literature, to consolidate these findings.

6.2.1   The emergent model: Diverging attitudes towards the role of post-qualification personal therapy

What the narratives of participants seem to suggest is that the role of PT as an activity for CPD, to be engaged in post-qualification, is not clearly defined or understood. The core category *diverging attitudes towards the role of post-qualification personal therapy* was thought to incorporate all the narratives embedded in the other categories and to represent a theoretical framework of how qualified counselling psychologists view and understand the role of PT post-qualification. The model emerged from five main categories, which reflected the aims of this study: (i) personal growth versus personal crisis; (ii) "practice what you preach"; (iii) the ideal therapist; (iv) compliance and confusion of compulsory PT as trainees; and (v) approval, ambivalence and constraints of PT as post-qualification CPD.

6.2.2   Personal growth versus personal crisis

The category *personal growth versus personal crisis* supported the first and third aims of this study, specifically factors contributing to why counselling psychologists would or would not engage in PT post-qualification, and their views of PT as a post-qualification CPD activity. This category represented four subcategories: (i) personal therapy as an intimate space; (ii) learning to identify and to work with transference and

countertransference; (iii) personal therapy as a self-care resource; and (iv) personal therapy when in crisis.

Many participants expressed a sense of their PT representing an intimate personal space, a place for on-going self-reflection and to develop a better understanding of oneself. The unique characteristics of therapy, being in a space which is solely dedicated to oneself, were felt to be different to the 'clutter' that can be present in other relationships. This viewpoint of the therapeutic relationship or setting as an intimate space has been identified by Norcross and Connor (2005) who found that the primary reasons therapists reported for seeking PT related to the private non-professional sphere of the person, for personal growth and to explore things outside of their personal relationships so to avoid encumbering these.

Orlinsky and colleagues (2005) also reported that most therapists in their study had taken part in therapy at some point in their lives, with the most commonly cited reasons for entering PT being personal growth, personal development, and enrichment. In this study, therapists who had sought PT also expressed wanting to find a way of creating a personal space that was and different from their other relationships in their lives with family, friends and colleagues.

Countertransference in the broad sense is used to describe a therapist's feelings and visceral reactions in relation to the client, which are a response to the client's transference (e.g., the client's unconscious feelings towards the therapist) (Arundale & Bellman, 2011) and/or the therapist's own material (Kahn, 1997). Just as participants such as Della felt that her compulsory in-training PT helped her to notice her own internal reactions to her clients and to use these in therapy to aid the therapeutic process, PT post-qualification was also considered by some participants to provide them a place where they could learn about themselves, and about themselves in relationship with others including their clients. This aspect of PT was seen to contribute to both their

personal and professional growth. Participants in this study felt that their own PT had enabled them to work on some of these issues that may have impacted their practice, with some, such as Bob and Patsy expressing their view that a counselling psychologist who does not work on these could be possibly limiting the effectiveness of their work, or causing harm to clients.

The three participants, who had not chosen to engage in PT post-qualification, felt that they had learned about recognising and working with transference and countertransference whilst engaging in their compulsory in-training therapy, and did not consider that they would require PT to manage these phenomena as they arose in their therapeutic encounters with their clients. This was perhaps influenced by the orientation of their practice, as many participants in this study such as Susan, Kate, and Della, worked in the NHS, predominantly offering more goal-oriented time-limited forms of therapy, such as brief CBT interventions for anxiety or depression, in which transference and countertransference are not the focus of the therapeutic work. Participants such as Bob and Dave, who practiced longer-term psychodynamic-oriented therapy, which places a greater emphasis on doing work on interpersonal and intrapersonal relationships, issues of transference and countertransference are considered to be important tools of therapy and working with these are central to the therapeutic process. Thus, counselling psychologists who do a greater proportion of their work in this way are more likely work mostly on uncovering hidden aspects of themselves, as this is an integral part of the therapeutic process and interventions.

Personal therapy as a self-care method has been found to impact positively professionals in the helping field to maintain a sense of resilience and wellness (Skovholt, Grier & Hanson, 2001), and this was also reflected in the experiences of some participants, such as Jan, and Bob. These participants described their PT post-qualification as a form of self-care and in reducing stress. A common theme present in

the accounts of those participants, who had engaged in PT post-qualification, was that it enabled them to feel emotionally resilient and more resourced as a professional, consequently impacting positively on their perceptions about their work with clients.

Nevertheless, several participants including those who had not engaged in any post-qualification therapy (Susan, Kate, Della), and some who had (Patsy and Joanne), gave accounts of alternative activities they had engaged in to deal with professional or personal difficulties or pressures, and as a way to resource oneself. For instance, family and friends would be relied upon for support at difficult times or for help with a problem, and relaxing activities such as holidays, breaks, massage or meditation could be used as a means to unwind or create some personal time to reflect.

The engagement in alternative activities by helping professionals supports in part the study by Stevanovic and Rupert (2004). They found that professional psychologists manage and sustain the personal and professional self by attaining a balance between nurturing connections with families, friends and other social groups that are enriching. Mahoney (1997) also identified a variety of self-care activities including mediation or prayer, physical exercise, or artistic enjoyments being engaged in by therapists as a way to replenish oneself. Although neither sample included counselling psychologists specifically, these findings do suggest that it might be more common for practicing therapists to engage in non-therapy forms of self-care than it is for them to engage in PT.

Several of the counselling psychologists interviewed (Jan, Kate, Susan) reported engaging in PT in times of a crisis, such as bereavement, relationship breakdown or loss of employment. This is consistent with previous studies, including Norcross and colleagues (2008) who conducted a survey of over 700 psychologists and psychotherapists in the United States. They reported that the most common reasons cited for engaging in therapy were: personal or professional pressures, the death of a

loved one, stress, marital difficulties, and the perception that therapy would be beneficial.

Nevertheless, some participants in the present study (Bob, Joanne, Patsy) did view their PT post-qualification as primarily as a means of self-exploration and self-reflection, and this was the reason why they had engaged with therapy. Differences were also present in the length of time participants had chosen to engage in therapy. Participants seeking to engage in therapy for personal reflection or personal growth were in therapy for longer periods, compared to those who sought therapy during a crisis.

In her book *The therapeutic use of self*, the psychotherapist Wosket (1999) draws a distinction between what she considers to be a more superficial level of work on the self - personal development, and the depth of engaging in PT in order to perform an internal searching of the self, working through unresolved conflicts and aiming at personality changes. Wosket (1999) illustrates this with a gardening metaphor: you can choose gardening that eradicates every tiny weed, or gardening that pulls out only the large weed. Thus, there may be an overlap between the way counselling psychologists work and what problems they treat, and the reasons they might engage in PT themselves. This notion of one's PT aligning to the therapy one practices is explored further in the discussion of the next major category.

6.2.3 "Practice what you preach"

The major category *practice what you preach* supported aims one and two of this study, specifically factors contributing to why counselling psychologists would or would not engage in PT post-qualification, and their views of how PT contributes to their personal and professional development. Almost two thirds of the therapists in this study had engaged in PT post-qualification, and thus could be seen to be "practicing what they preach" – that is, their belief in the value of therapy for others was consistent

with their belief in the value of therapy for themselves. The sub-category *being congruent* represents this idea that it is important for a counselling psychologist to be able to practice in an authentic way, to be prepared to experience and understand for themselves what they expect their clients to experience and understand, and to not view therapy as only something that 'others' can benefit from. Aware that some practitioners chose to engage in alternative activities as self-care and self-reflection and had not engaged in PT since the compulsory therapy during their training, some participants in the present study considered that these practitioners were lacking congruence or authenticity – holding conflicting views about the value of therapy for others, and the value of therapy for themselves.

The issue of practitioner congruence, grounded in an ability to be able to "practice what you preach" has been referred to by several authors. For instance, in a chapter entitled *Making therapy work, or practice what you preach*, Kramer-Moore and Moore (2012) point out that "no technique can substitute" for PT in terms of helping therapists to understand their own weaknesses and defects. They continue to describe how some therapists express an "attitude of omnipotence" in which they believe that their education and years of practice makes them trustworthy for their clients, suggesting that this view is incorrect.

Three participants (Susan, Kate, Della) revealed that whilst they viewed PT to be an essential component for the continual personal and professional development of the counselling psychologist, they had not themselves engaged in PT following qualification. Participants reported several factors influencing their non-engagement including seeking alternative self-care activities, financial and time constraints, and difficulty in finding a suitable therapist. All the factors seem to be linked with accessibility of therapy and the need to allocate time to search for and attend therapy. These findings are similar to those reported in larger-scale survey-based studies of

psychotherapists and counsellors (Orlinsky et al., 2011; Norcross, 2005). In an international study of almost four thousand psychologists, counsellors, social workers, psychiatrists and nurses, Orlinksy et al., (2011) found that at least one episode of PT had been engaged in by 87% of all participants, with 84% of UK psychotherapists particularly (n=1000) having done so. Among the primary reasons for not seeking therapy were solving problems before therapy was required, using family and colleagues for support, using supervision instead, and concerns about confidentiality being maintained.

The notion of therapeutic orientation referred to in the previous major category might not only affect the reasons why a counselling psychologist would seek therapy in the first place (e.g., personal growth vs. personal crisis), but also their views on whether or not engagement in therapy is an expression of congruence post-qualification. Participants such as Bob and Patsy, who practiced longer-term therapy with more emphasis on the psychodynamic aspects of the work, felt they would not be practicing congruently if they were not prepared to examine their own issues within their own therapy. As many participants in the present study worked in the NHS, predominately offering time-limited goal-orientated therapy, there would be less opportunity to work on these interpersonal dynamics in therapy, and consequently be less necessary to be in PT oneself.

The role of therapeutic orientation in engagement in PT has been identified in a survey examining 476 psychologists' experiences, problems and beliefs of PT (Pope & Tabachnick, 1994). In this study, psychodynamic therapists were most likely to have been in therapy (94%), followed by 87% of eclectic therapists, 79% of other therapists, and 71% of cognitive therapists. This perhaps represents how psychodynamic therapists, because of their emphasis on the self of the therapist in clinical practice, are perhaps more encouraged or curious to engage in PT.

Alternative means of resourcing oneself – whether instead of PT for those participants who had never engaged in any, or when PT could not be afforded or was not currently being utilised – included going on holiday, taking a relaxing spa break, attending church or praying, being with friends, meditation retreats, talking to family and partners, and attending regular social meetings with colleagues. These are represented by the sub-category *alternative methods of self-care.*

Despite many of these activities being very different to PT, for participants who reported not seeking therapy these alternative self-care activities may well act as a way to reduce stress, gaining support and as a way of self-care and were viewed by some participants, such as Kate, as improving their performance as a therapist non-specifically, by relieving stress and tension. Indeed, as Kate stated, the work of a therapist can be "emotionally debilitating", and thus engagement in such alternative self-care activities is a protective factor against the additional stress and exhaustion related to their professional practice. Nelson-Jones (2005) considers that that engaging in any activity from which a therapist can find some relief, whether emotionally, psychologically or physically are helpful as a way of de-stressing from their role.

Practice what you preach is an attempt to reflect the inconsistencies between some of the participants' view (e.g., it was important or useful for qualified practitioners to engage in PT) and their actions (e.g., their having not personally engaged in any post-qualification therapy). It also reflects the idea that a counselling psychologist might be being congruent even if they haven't yet engaged in PT, because this is consistent with their view of what types of problems therapy is useful for treating – problems they have not yet experienced (e.g., crisis, depression).

The theory of planned behaviour (TPB: Ajzen, 1985, 1991) might be used to understand this process. According to the TPB model, individuals' actions are generally controlled by intentions, but intentions alone do not predict behaviours (Ajzen, 1985). It

is proposed that behaviours and intentions are determined by: the individuals' positive or negative evaluation of performing certain behaviour; the individuals' perception of social pressure in performing or not performing a certain behaviour; and their perceived ability to perform the behaviour of interest (Ajzen, 2005). The theory of planned behaviour may provide an explanation for why some participants, despite disclosing that they thought therapy was a beneficial activity for the counselling psychologist, did not engage in it themselves. The issue of perceived social pressure might influence non-engagement in therapy (e.g., where there may be real or perceived social pressures within the workplace to present a competent and resilient professional self, or a feeling that one is being judged for requiring therapy).

6.2.4 The ideal therapist

Not showing vulnerability and *seeking a good-fit therapis*t were two subcategories that emerged through participant's accounts and were represented by the major category *the ideal therapist*. This category supported the first aim of this study, to understand the reasons that counselling psychologists engage (or not) in PT post-qualification. Participants expressed a concern, originating mostly from within themselves rather than imposed upon them by their workplace or the demands of others, to present a professional self and not reveal any vulnerability. For instance, Kate speaks about her own need to appear "100%" (i.e., ideal, perhaps even 'perfect') at work, yet also recognised that her employers were supportive. For Kate, the demands that she placed upon herself to be 100% could be viewed as 'irrational beliefs' though the lens of rational emotive behaviour therapy (Ellis & Dryden, 1997). Such beliefs can lead to a reluctance to engage in PT underpinned by other beliefs that being in therapy is a sign of imperfection, or even weakness. Through the TPB model (Ajzen, 1985, 1991) this could help to explain the ambivalence in behaviours some practitioners regarding engaging in PT for themselves. However, this model may not take into account factors

such as beliefs that therapists may hold, such as not wanting to appear vulnerable as expressed by Kate, but also the acknowledgement of Dave that false pride may be further factor which inhibits the professional counselling psychologist from seeking therapy

Another aspect of the need to appear invulnerable, related to one participant's (Dave) suggestion that some qualified counselling psychologists might be reluctant to engage in PT, or not consider PT at all, due to a sense of "false pride". This was considered as a possible defence mechanism, protecting the counselling psychologist from hidden feelings of incompetence, or at least 'less-than-perfect competence'. Perhaps this also represents an irrational belief, or implicit attitude, that "the ideal therapist" 'should' be able to take care of themselves without input from other professionals. Other studies have found that therapists' reasons for not seeking PT themselves includes a fear of exposure (e.g., Norcross & Connor, 2005; Stefl & Prosperi, 1985), and Norcross and Connor (2005) also found that a "sense of self-sufficiency" prevented some therapists from engaging in therapy. These findings related both to the need to appear competent and invulnerable, as well as a possible false-pride, in needed to feel one was able to take care of one's own needs.

6.2.4.1   *Role identity theory, perfectionism and burnout*

Role identity theory (McCall & Simmons, 1978) is one potential framework around which to explore help-seeking attitudes among helping professionals. An individual's identity is conceptualised as being *social*, reflecting a person's place in society that is socially constructed, but also *personal*, reflecting the idiosyncratic nature and characteristics of each person (McCall & Simmons, 1978). According to this theory, individuals who hold a certain social position or role (for example 'counselling psychologist') will have numerous expectations, arising from their own internal expectations and those of society, as a result of occupying that particular social role.

Siebert and Siebert (2007) propose that role identity theory is well placed to explain why helping professionals may struggle to seek help, as their role is framed as giving rather than receiving support and being in a position of power compared to their clients. These authors examined role identity and its influence in help-seeking behaviours among helping professionals. They found that among distressed practitioners the main reasons for seeking help was depression, and that burnout and impaired practice did not increase the likelihood of seeking help. The notion of role identity and the creation of the idealised professional caregiver was associated with an increase in personal distress (for example depression, burnout), that subsequently impacted negatively on practitioners' professional work. This may explain why some highly experienced counselling psychologists in the present study felt unable or unwilling to engage in therapy.

Efforts made to maintain perfectionist standards can lead to professional burnout, as perfectionist behavioural patterns can drain a person's mental energy, to the point that they lose interest in the activity and can disengage from it (Taris, Beek & Schaufeli, 2010). Studies investigating burnout have found this to be prevalent among professionals providing counselling and psychotherapy (Figley, 1995; Mahoney, 1997), with effects of burnout on clinical practice including a loss of empathy and respect for the client and being unresponsive to their needs (Skorupa & Agresti, 1993). Professionals offering therapy and caring for patients often fail to notice the need to focus on their personal self-care and burnout, not attending to symptoms of burnout is more likely to lead to disruptions to empathic abilities, consequently impacting and limiting therapeutic treatment (Neumann & Gamble, 1995). As a significant percentage of mental health professionals are affected by psychological impairment at some point in their career (Guy, Polestra & Clark, 1989), it is important to find ways to support these professionals for their well-being and their clients.

6.2.4.2   *Choosing a therapist*

When speaking about their actual, or hypothetical, search for a therapist of their own, qualified counselling psychologists in the present study considered a number of different factors. These related to professional skills, such as competence in their practice and use of therapeutic skills, which was linked to their training and years of clinical experience, and personal qualities such as an awareness and understanding of difference and experiences of being different (i.e., ethnicity and (dis)ability), or shared belief systems. Certainly, reputation, education and training have been identified in other studies as factors that are important to therapists when selecting a personal therapist of their own (Gilroy, Carroll & Murra, 2002).

In terms of personal or relational aspects that were identified as important by counselling psychologists in the present study when selecting potential personal therapists, Norcross et al., (2008) also noted in their survey study of over 700 American psychologists that 119 many participants reported that the process of engaging in PT was hindered by not being unable to find a therapist with whom they felt comfortable. Writing about how PT affects therapists' practice, Macran and colleagues (Macran & Shapiro, 1998; Macran, Stiles, & Smith, 1999) considered the benefits of PT to relate to the role of the therapist (humanness, power, boundaries), the role of the client (trust, respect, patience), and to the therapeutic relationship. Thus, these personal and relational aspects, including humanness, trust and respect might be considered as being important when considering to engage in therapy and to select a personal therapist, perhaps more so than the skills and experience of the therapist.

This category reveals differences in how counselling psychologists select a personal therapist: some appear to emphasise and value factors relating to concrete, quantifiable technical and professional skills, whilst others seek a therapist whom they feel they can find a deep meaningful connection, and with whom they felt comfortable.

6.2.5 Compliance and confusion of compulsory personal therapy as trainees

The category *compliance and confusion of compulsory personal therapy as trainees* was unexpected and did not reflect any of the study aims, which were focused on understanding counselling psychologists' views and experiences of post-qualification PT. However, this finding still informed the initial aims of the study as it contributed to a greater understanding of how past experiences can shape future choices and decisions.

Whilst the present study was primarily interested in understanding qualified counselling psychologists' use of PT post-qualification (i.e., when it was no longer compulsory), several participant's accounts, especially those who had not engaged in any post-qualification therapy, revealed how aspects of their compulsory therapy had influenced their subsequent attitudes about and engagement in therapy.

Additional questions about this aspect of training revealed that many participants felt that PT was insufficiently integrated and emphasised during their counselling psychology training, consequently making them feel that this aspect of learning was disconnected from the course. This lack of explanation and emphasis on the role PT was supposed to play within the training context, as well as a failure to provide practical information about how to select a therapist, what to expect from therapy, and how to decide whether a therapist or therapy was beneficial, made therapy feel like a confusing process.

The lack of emphasis and integration of PT during training supports reflects previous research findings. McEwan and Duncan (1993) found that half of their sample of 400 trainee psychologists' who had undergone therapy as part of their training as counselling psychologists did not feel informed about therapy, did not feel it was sufficiently integrated in the course, and over one-third of participants reported that the effect of PT on students was not monitored by the faculty.

Participants' accounts also revealed at times an ambivalent or resentful attitude towards their compulsory PT. Not understanding the importance of this aspect of their training, it was treated more as another assignment, with the minimum requirement to be completed as soon as possible that would also relieve the financial burden of the therapy. The decision to remain in what was being experienced as unhelpful therapy was either because they thought that difficulties were part of therapy, because they just wanted to complete the required hours, or they did not want to spent time finding another therapist.

An individual's expectancies are one factor that can impact upon their motivation and engagement in a particular behaviour. Outcome expectations are influenced by how well an individual believes they could perform the task in question – or perceived self-efficacy. Efficacy beliefs are also related to the degree to which an individual considers that an activity would be useful and beneficial (Bandura, 1994, 2012) In other words, people will be more likely to intend to engage in a particular activity such as PT, if they believe that they would be able to be competent at the therapeutic process (e.g., being able to be challenged, honest, vulnerable, perform required homework activities etc.), and that PT would be a useful activity and an efficacious way to resolve difficulties or reach their goals for (Zimmerman, 2000). Conversely, low self-efficacy beliefs about one's competence and the utility of a particular activity will make it less likely that an individual would be motivated to engage in that activity. The negative experiences of PT reported by several participants in the present study might have contributed to their holding lower self-efficacy beliefs both about their competence as 'a client' in therapy, and of the potential benefits of therapy versus other forms of support. In turn this would have influenced their attitudes towards PT post-qualification and intention to engage in it should a need arise.

Earlier research by Aveline (1990) also indicates that approximately a third of trainees interviewed felt that their feel that PT during training was not a helpful experience, and had a negative influence on their clients. Personal therapy during training has been proposed to interfere and cause distraction to trainees (Clark, 1986; Wheeler, 1991), and several studies have reported that PT can lead trainees to experience depression and rumination (McEwan & Duncan, 1993). Other unhelpful effects of therapy that have been found include the non-resolution of issues, difficulties in the relationship with the therapist, and higher levels of stress (Grimmer & Tribe, 2001; Kumari, 2011).

One consequence of these account of negative in-training therapy experiences is that some authors have begun to challenge the assumption that PT during training is always desirable, suggesting that the overall outcome of work with oneself is not always a desirable aspect of training, as it is challenging and arduous (Atkinson, 2006; Kumari, 2011). The uncomfortable and negative experiences of therapy during training that cause the therapy to be perceived as 'unhelpful' could be more usefully conceptualised as learning points for the trainees, if their training courses were able to provide the 'integration' that several participants felt were lacking on their own training.

Whilst the present study only interviewed a small sample that is perhaps unrepresentative of the wider profession of counselling psychology, it did shed light on a possible connection between these unhelpful compulsory therapy experiences, and whether that counselling psychologist went on to engage in PT once qualified. At least half of the participants in this study reported confusing and unhelpful experiences of PT, with three participants reporting that they had not engaged in PT following qualification. However, it was not clear whether this was entirely because of their previous unhelpful experiences, because they had found and made use of alternative

means of self-care, or because they viewed therapy as mostly useful for crises, which they had not experienced personally.

6.2.6 Approval, ambivalence and constraints of personal therapy as post-qualification CPD

The category *approval, ambivalence and constraints of personal therapy as post-qualification CPD* supported the third aim of the study, which was to explore the role of PT as a possible CPD activity for qualified counselling psychologists, as currently it is not suggested by the HCPC. Participants in the present study were asked about their views of PT as a CPD activity – whether voluntary or mandatory.

Overall, there was an appreciation for the value of PT with the majority of participants, including those who had not personally engaged in any post-qualification therapy themselves, favouring PT as a voluntary activity for continuing personal and professional development. Some participants felt that their PT post-qualification allowed for a deeper exploration of issues they had chosen to explore or that had arisen organically, rather than feeling forced to address an issue or having no issues they wanted to discuss in mandatory therapy. Participants also felt that therapy as a professional allowed them to have a better understanding of the therapeutic process, as they could focus more fully on the therapy without additional concerns and anxiety about their training course, and they felt more confident to establish what they wanted to explore and achieve from therapy.

Participants were less sure about PT being made a compulsory requirement of CPD. Some of the reasons for this were practical – time constraints and costs and other commitments. Financial pressures were generally a barrier to engaging in PT post-qualification for several participants, and the financial burden had also been difficult to bear during their training. Participants' seemed to suggest that voluntary therapy brings with it the freedom to decide when to engage in therapy and for how long, what issues to explore or what goals to set for the therapy, and what type of therapy to select. This

makes the experience more genuine and consequently the counselling psychologist can gain more from it.

Previous experiences of PT during training had for some participants shaped the way they viewed the potential role of PT in professional development and CPD. Those who had engaged in PT following post-qualification were more likely to favour PT as an activity to engage in, at different points in life. Participants who had not engaged in PT post-training were more ambivalent of its role in CPD, but were still open-minded about the benefits therapy could bring for others. A point made by some participants was that professionals should be trusted to decide for themselves when to engage in PT, rather than it being imposed on them.

Whilst the use of PT for personal and professional development may not be a mandatory activity stipulated by the HCPC, the majority of participants in this study did engage in PT as qualified professionals, although the reasons for doing so varied from continuing to work on the self to relieve stress and pressures of personal life to have a personal space outside of normal relationship. Participants who had not sought PT post-qualification engaged in alternative activities as a way to manage work and personal issues and stress. Ongoing PT is one way of ensuring that counselling psychologists who deliver therapeutic interventions to clients have psychological support to manage issues that arise for them in their work or in their personal and emotional lives, ensuring that these issues do not leak into their work, and potentially impede or even harm their clients' progress in therapy. In this sense, PT is a form of ethical practice in that it supports safe working practices, whether at the conscious or subconscious level.

Certainly, there is some evidence that psychologists can be reluctant or are unable to identify problems in themselves, but are more readily able to identify similar problems in colleagues (Guy, Polestra, & Stark 1989; O'Connor, 1998). Guy, Polestra

and Stark (1989) reported that psychologists continued to work even when feeling too distressed and despite knowing it was unprofessional to do so.

There are numerous ways that qualified counselling psychologists can ensure their continual professional development, including training, supervision, peer group support, reading, and attending conferences and updating their knowledge of the types of clients and issues they encounter in their work. Within this array of CPD activities, PT might only be viewed as a necessary activity for those who adhere to the view that their own self (as an instrument within the intervention and the therapeutic relationship) needs to be understood, and managed, in order to work safely and ethically with their clients, and to protect their clients from possible contamination and harmful effects of their own personal experiences, unresolved issues, blind spots and defence mechanisms.

6.3 Contribution to Knowledge

There is a relatively limited amount of research exploring the role of PT specifically for qualified counselling psychologists in the UK. The findings from this study therefore contribute to our understandings about the possible role of PT for qualified counselling psychologists in four key areas, which are discussed in terms of how they relate to the original aims of the research.

6.3.1 Aim 1: What factors contribute to why counselling psychologists do/do not or would/would not engage in personal therapy post-qualification?

Firstly, the study presents some preliminary new knowledge about if and why qualified counselling psychologists engage in PT post-qualification and why they might not. The factors that have arisen from these findings include:

Self-care: Personal problems and issues. Several participants revealed that they engaged in PT to process personal and emotional difficulties, such as the breakdown of a relationship or change of employment. PT was also engaged in as a self-care resource, to reduce stress or to work through a particular crisis in life (e.g., bereavement, loss of health). Some participants had not engaged in PT post-qualification because the

conditions for which they considered they might seek it had not yet arisen. Findings from this study suggest that PT could perhaps be considered as a tool for practitioners of psychotherapy to alleviate some of the emotional burdens they may carry, so that this does not impact their physical and emotional health and life in general.

Self-care: Work-related issues. Personal therapy was also viewed as one way to address burnout and remain a resilient person and practitioner. Some participants considered PT to be a place where they could learn about and work on countertransference that arose within their therapeutic relationships, which helped their applied work with clients. Identifying, understanding and working through these unconscious and non-verbal processes in PT was considered by many participants as benefitting their clinical practice and facilitating the therapeutic work. Engagement in PT in this manner could be considered a CPD (i.e., developing the self for the purposes of professional development) activity for counselling psychology practitioners.

Self-awareness and personal development. PT was also used for self-reflection and to develop better self-awareness as a person and as a professional practitioner. It was felt that PT enabled a deep focus on ones interpersonal and intrapersonal ways of relating and how this then impacts on life in general, including their professional practice. To perform their therapeutic work, counselling psychologists require a high level of self-awareness and introspective abilities, as well as the capacity and sensitivity to pick up non-verbal communication; mandatory in-training PT is used to facilitate this learning. Engagement in PT post-qualification is one way of continuing to learn and developing these skills via self-awareness and personal development.

Professional congruence. It was the opinion of some participants that, by engaging in PT, they were being congruent and authentic as a professional, viewing therapy as not something that only 'others' can benefit from. Relatedly, some participants also expressed views that counselling psychologists who did not engage in

PT might be incongruent in their practice, considering that these practitioners were not necessarily practicing what they preached. Some participants considered that false pride might underpin some psychologists from not engaging with PT. However, it should be noted that some practitioners work in complex needs settings, supporting clients who are experiencing severe distress and trauma. Psychologists' exposure to this type of client might affect the extent to which they 'downplay' or feel guilty about their own personal issues, and therefore the extent to which they consider that psychotherapy is necessary for them.

Therapeutic orientation. A further factor that could influence a qualified counselling psychologist's engagement in PT is their therapeutic orientation, and specifically the degree to which the style of therapy they practice. Several participants who practiced an integrative approach considered PT to be integral to their professional practice, viewing the development of the self as an important aspect and tool of the therapeutic process. Perhaps counselling psychologists who practice from an integrative and psychodynamic approach are more inclined to use PT, as this is perceived as being linked to their clinical practice just as clinical supervision currently is for most if not all psychotherapy practitioners.

Presence relevance of other alternative and forms of care or development activities. Participants who had not sought PT following qualification, and some who had, revealed using alternative methods of self-care, such as relaxing breaks, massage, church, supervision and peer support. These activities were engaged in as a way to relieve some of the pressures from life and work, just as PT can be used by some people. Whilst these activities can be considered effective for relieving distress and for disengaging the mind and body, these are different to PT which requires one to cognitively and emotionally engage in the process of self-discovery, which may not necessarily be a smooth and relaxing process. Nevertheless, if these activities provide

some emotional and physical relief then they are also effective strategies for managing the self.

Past experiences with personal therapy. A finding that was not anticipated in the interview schedule (i.e., participants' views were not sought on this theme) but emerged as a category, was how uncomfortable or unhelpful experiences of compulsory PT during training contributed to later attitudes towards or use of PT. There seems to be some indication that this compulsory in-training PT could be integrated more coherently into the other parts of the training process for counselling psychologists so that they were able to connect their experiences in PT to the empirical and practical aspects of their learning.

6.3.2 Aim 2: How can personal therapy contribute to the personal or professional development of qualified counselling psychologists?

The study presents some preliminary new knowledge about how PT might contribute to the personal and professional development of qualified counselling psychologists. The findings do highlight the need for qualified counselling psychologists to be able to manage the self professionally, including how they respond to work-related stress, the emotional burden of the job, and to prevent burnout. PT was not considered by all participants to be an essential aspect of their therapeutic practice or professional development. Here, PT was viewed as one potential activity among others, including friends and family support and peer supervision. In the present study, several participants discussed feelings of burnout, stress, coupled with a desire to appear perfect (Kate, Dave, Bob, Joanne, Jan, Patsy) and the notion of "false pride" as an obstacle for seeking PT as a qualified counselling psychologist. This is particularly pertinent in light of the concerning findings of the latest British Psychological Society and New Savoy staff wellbeing survey for 2015 (BPS, 2016). This survey found that almost half of psychologists surveyed report depression, half felt they were a failure,

and 70 per cent found their job stressful. These were all increases over the same survey in 2014, with stress up by 12 per cent and incidents of bullying and harassment nearly doubling. The possible stigma attached to the professional who provides therapy then needs therapy themselves could be tackled by making PT more accessible and integrated in the workplace as clinical supervision currently is.

Engaging in PT meant, for some participants, that they were being congruent with their beliefs and practice, at the same time ensuring that they practiced in a safe and ethical manner, and developing their self as an instrument of the intervention, including through being more aware of their own impact on the therapeutic process.

6.3.3 Aim 3: Views of personal therapy as a potential CPD activity for qualified counselling psychologists

The study also sought to gain a clearer understanding of whether ongoing PT should be included an optional or compulsory CPD activity for qualified counselling psychologists, particularly in terms of how PT might support ethical and competent practice. According to the HCPC, as outlined in section 2.3, CPD consists of a range of learning activities through which psychologists "maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice", and CPD should "benefit the service user" (HCPC, n.d.).

This view of PT as something to be engaged with in order to be a better practitioner seemed to be related at least in part to the therapeutic orientation of the participant: those who practiced open-ended reflective or psychodynamic-oriented therapy considered PT to be an important tool for developing themselves as a professional and to remain an ethical and competent practitioner, rather than expanding their professional skills and knowledge. Participants who oriented to more practitioner-led therapeutic models, such as brief structured therapy, did not seem to consider self-

reflection or self-awareness facilitated via PT to be necessary in terms of their own practice or work with clients. There are certainly differences between how centrally various therapeutic models place the relational aspects of the work, including transference and countertransference, the therapeutic alliance, and the self of the therapist (Aponte, et al., 2009; McConnaughy, 1987; Mearns & Thorne, 2007; Reupert, 2006). These differences are likely to influence the extent to which practitioners view the importance and relevance of the 'person of the therapist' (McConnaughy, 1987; Aponte & Winter, 2000) in the therapeutic process, and thus the necessity for continuing to developing the self (via PT) as a tool within their therapeutic interventions.

If CPD consists of a variety of activities through which psychologists "maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice" (HCPC, n.d.), then PT could be considered to be an appropriate CPD activity. As views of PT formed during training influence later attitudes towards it, it will be important that PT is not only integrated during the formative years of training as a counselling psychologist, but also in subsequent years as a professional under CPD. This is specific to the practice of counselling psychology, but could also encompass other psychotherapy professionals. If PT is to be considered as a CPD activity might also be integrated into the workplace as an additional source of personal support and underpinning safe practice, as clinical supervision currently is. This is discussed further in section 6.5.

6.3.4 Unexpected finding: The experience of personal therapy during training

Finally, an unanticipated contribution of the study – that is, it was not anticipated or built into the interview schedule - is that it illuminated how compulsory PT during the training of counselling psychologists could be an uncomfortable, and not necessarily beneficial, experience for some participants. Trainees are required to use PT

to develop their self-awareness and reflective abilities, learn about therapy, experience a client's perspective, and explore ongoing difficult personal issues. However, several participants recalled that they had been unable to make connections between the PT they were engaged in during their training, and what they were learning and practicing elsewhere on their training program. Others viewed their in-training PT as a course requirement that could be costly, as well as uncomfortable, and consequently sought to complete it as soon as they could. Most therapists know that it is preferable to have a motivated client who has chosen the course of treatment themselves, rather than a coerced client who does not want to be there. Feeling that one 'has to' engage in PT, rather than electing to enter therapy oneself for an identified personal need or problem, is likely to result in trainees not benefitting as much from the experience as it is intended or thought that they do. Some participants (Kate and Della) stated that negative experiences with their therapy as trainees had affected their opinion or use of PT post-qualification (and thus past experience of therapy can be viewed as factor influence future use of therapy), although they did consider alternative activities for self-help and professional development, such as clinical supervision, peer supervision, church and holidays. Given that people can experience harmful as well as beneficial effects of therapy (Crawford et al., 2016), this is certainly an area worth exploring in more detail. It also suggests that there might be value in exploring whether any improvements could be made to how trainees are educated about, and supported with, their PT requirement.

In the following section the implications of these findings in relation to the training, practice and professional development of counselling psychologists are discussed.

6.4 Implications for the Training of Counselling Psychologists

This study hopes to raise discussions of how PT might be better integrated in professional training, through introductory lectures on PT to new students and forums

where students can discuss questions they have about therapy, the therapeutic process, its costs, what to expect from therapy and many other issues. This study also introduces the idea of PT being perhaps monitored during training to ensure that trainees' negative experiences of PT are minimised.

Psychotherapy is not simply benign when it is not beneficial, but can be potentially harmful. It is already established that some people experience negative effects from psychotherapy (Macaskill & Macaskill, 1992; Pope & Tabachnick, 1994; Rake & Paley, 2009) and a recent study (Crawford et al., 2016) has added to the evidence for the prevalence of harmful therapy outcomes. From a sample of over 14 thousand respondents, 5.2 per cent reported experiencing lasting negative effects following therapy. Crawford and colleagues (2016) also found several factors that might increase the likelihood of a self-reported harmful effect of therapy, including that people who were unsure what type of therapy they received were more likely to report negative effects compared to those who reported that they were given enough information about therapy before it started. The authors made recommendations based upon their findings of what factors could help reduce the risk of harmful outcomes, including ensuring the client understands the therapy process and the type of therapy they are receiving, and that they are provided informed consent based upon the potential for harmful as well as positive effects of the therapy (Crawford et al., 2016). This could improve their therapy experience during their training, and arguably increase the likelihood of them seeking therapy in future, post-qualification.

The monitoring of the progress and experience of therapy for trainees, as suggested by some participants, could provide a way to strengthen and maintain the sense of PT being an integral aspect of the course. Although the close monitoring of PT may appear restrictive and unhelpful, Connor (1994) argues that assessing personal development can empower the trainee, facilitate their growth while meeting

requirements set out by professional training courses. It is suggested that perhaps if training courses were to monitor more closely PT this could be helpful in reducing or preventing harmful experiences of therapy, by providing trainees with more knowledge and information on PT.

The world of therapy can appear especially daunting for a trainee who is in search of a therapist. Promoting discussions on PT more openly during training would offer guidance to trainees on how to look for a therapist, the different theoretical orientations available, and some way of understanding the emotional impact of therapy. Further, as some trainees may not engage in PT later in their life (as it is not a compulsory CPD activity), it is even more important that experiences of therapy during training are beneficial and useful to the trainee, and not harmful to be avoided or to simply as a tick-box exercise.

Providing a "good enough" experience of PT for trainees during training, one that is less confusing and daunting, may influence counselling psychologists' attitudes towards PT in future. Better integration of compulsory PT into the training programme will hopefully produce more useful experiences of PT, which can enhance attitudes and self-efficacy beliefs about PT post-qualification.

One may argue that negative experiences are present in many cases in therapy. With regards to some of the negative experiences of therapy reported in this study there could be other reasons for these harmful experiences. For example, not all training institutions specify that the therapist needs to be a counselling psychologist and some of these bad experiences might potentially arise if students seek the cheapest possible therapist, who may just be adequately experienced.

6.5   Implications for the Continuing Professional Development of Qualified Counselling Psychologists

A further aim of the study was to explore how, or whether, qualified counselling psychologists considered PT could contribute to their professional development, and

their views of PT as a specific post-qualification CPD activity. It is hoped that the findings relating to this aim will stimulate some discussion on the role of post-qualification PT, to ensure continual safe, ethical and professional practice.

Participants were broadly in favour of PT as an optional CPD activity for qualified professionals, to be engaged in sporadically, whether to foster and increase self-awareness, also as a way of remaining authentic and congruent in their work, and enabling them to continue to work therapeutically with clients in a professional and safe manner by dealing with their own material that might otherwise affect their therapeutic relationships with their clients. Although PT is not currently listed as a CPD activity by the HCPC, as supervision is, the inclusion of therapy as a compulsory activity to be engaged in for personal and professional development was not considered helpful, as the motivation and choice of the therapist to enter therapy is removed in a mandatory therapy, and it perhaps does not exhibit trust in a qualified professional to take appropriate self-care measures.

The study identified how, for some therapists, PT can be used as one way to maintain ethical and safe practice, by allowing the therapist to become aware of, explore or resolve their own sensitivities and blind spots that might otherwise interfere with therapy. Personal therapy can also be used to develop professional skills and theoretical knowledge, by enhancing knowledge of theory and how this influences practice and to increase the therapist's skills and sensitivity in working with the inter- and intrapersonal dynamics that play out in therapy. Given how PT can support professional practice and development, the HCPC could allow registered psychologists to log some proportion of their PT hours as CPD, particularly those who consider their PT to have an impact on their applied work. This could also serve to encourage more qualified counselling psychologists to commit to the cost of therapy, as it could be viewed as being off-set against CPD expenses.

The findings of this study may have practical implications for counselling psychologists in the workplace. Difficulty finding a competent therapist and time required to travel to therapy were often reasons cited by participants as impinging upon seeking therapy. A suggestion is made for therapy being better integrated in the work place, as supervision currently is, making this a more accessible choice of emotional support, and underpinning safe practice, for practitioners. Figley (1995) suggests that organisations should perhaps do more to support practitioners deal with processing difficult clinical material, such as making available various resources such as regular supervision, PT, peer group support, conferences, professional development and team meeting. He also urges professionals to speak about their own challenges with burnout or compassion fatigue and not to be silent, as this encourages others to speak and it increases self-reflection and compassion in one's practice.

6.6   Evaluation of Study

The constructivist grounded theory method considers contextual factors, such as place, time, specific situation and relationships, which may influence the research process and analysis (Charmaz, 2006). The researcher acknowledges that the interpretation of participants accounts and that the derived construction of a theoretical model does not represent an absolute reality, but a reality which is socially constructed specific to a particular time, context and interpretation (Charmaz, 2006). Yardley's (2000) proposed criteria for evaluating qualitative research has been adhered to, taking into consideration: sensitivity to context; commitment and rigour; coherency and transparency; and impact and importance.

6.6.1 Sensitivity to context

Sensitivity to context was established by immersion in the literature studies in order to determine any gaps present in the present empirical research, used to contextualise this study. Sensitivity to participant's age, gender, professional

background and the researchers own position in the research was considered. The researcher was aware that she would be interviewing qualified counselling psychologists in the UK who had also undergone a similar integrative training, thus sharing similarities with. The researcher was reflective of how her position as a trainee may have influenced participants' responses in any way.

The researcher is also required to be sensitive to the data and mindful in the analysis phase to not impose their own meanings. Being reflective and attentive throughout the research process and ensuring that the emerging findings were a representation of participants' accounts, and not completely a representation of the researcher's views, was important.

6.6.2 Commitment and rigour

The researcher endeavoured to ensure that commitment and rigour were upheld throughout the research process. The recruitment of a relatively homogenous sample helped to include different perspectives and to achieve a thorough description of the topic investigated. Further, the researcher has been engaged in the study for the past four years and has undertaken all aspects of the research from the data collection, transcription of interviews and analysis. This was a painstakingly difficult and challenging process, which involved in isolation and at times sharing ideas and thoughts with colleagues and other students.

6.6.3 Coherence and transparency

Coherence and transparency requires ensuring and demonstrating that the research question, the epistemology adopted, and the method of analysis fit as a consistent whole. It was felt that the epistemological stance adopted in this research was in accordance with the qualitative methodological approach employed to answer the research question. In terms of transparency effort was made to ensure that all aspects of the research process were clearly outlined and explicitly documented. Participants were

informed of the research aim and purpose of the study, the coding of the data and various interview extracts have been included in chapter five and in the appendices section to demonstrate transparency of the research. Maintaining a reflexive stance throughout the research was also important to ensure transparency. This was achieved through writing of memos, taking notes and keeping a research journal to be aware of and question assumptions and beliefs held that could influence the study.

6.6.4   Impact and importance

Impact and importance refers to the study having practical and theoretical implications that are considered useful, which have been discussed earlier in this chapter. This study is considered important as it endeavoured to fill the gaps in the current empirical research on this topic, as addressed on the literature review chapter two. It is proposed that the findings from the present study may have implications for practitioners and training institutions by offering a new way to think about the integration of PT in counselling psychology.

6.7   Limitations

The following subsections will cover the critique of the methodology along with other methodological limitations present in this study, and recommendations for future research are made.

6.7.1   Critique of methodology

With eight participants in this study the findings from this study represent an interpretation of the data and cannot necessarily be generalised to a wider population. A quantitative study could have allowed for the recruitment of hundreds of participants, data being analysed more swiftly with computer software and results provided would be more objective and generalisable to a wider population. Grounded theory as a qualitative method of research with interpretations of data made by the researcher, and with different categories possibly derived by different researchers, could be criticised by

others as being obscure or unscientific (Denzin & Lincoln, 2000). Due to its lengthy and laborious process of transcribing and coding each interview and the attention to each participant's accounts, having a large sample in GT is not feasible. Thus, whilst implementing a quantitative analysis means more data can be collected, analysed swiftly and the results derived can be generalised; using with a qualitative study the researcher is analysing rich descriptive data of participant's accounts of a phenomenon understanding the subtleties of the issue being investigated.

A further critique of the grounded theory method is the epistemological differences present between the various forms of grounded theory and how theory is understood. For example, Charmaz (2006) makes a distinction between objectivist grounded theory and constructivist grounded theory. Objectivist grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) is more closely aligned to positivistic notions of reality and knowledge, assuming that through the application of rigorous grounded theory procedures, the researcher will obtain objective findings without influencing the research process (Charmaz, 2006). Conversely, constructivist grounded theory endorses the interpretative tradition of meaning in theory, and makes no claims of for generalisation, acknowledging the role of the researcher in interpreting the data and constructing a theory. A grounded theory is ultimately a social construction, and that it is in the relationship between the researcher and participant in their collaborative effort that meanings are co-created (Charmaz, 2006).

Finally, the notion of theoretical saturation in grounded theory presents a challenge to the researcher. Theoretical saturation is a point where the analysis of data ceases to produce new categories or new ideas, and the sampling of participants discontinues. Determining when one has reached theoretical is problematic, as knowing when to stop the analysis is not straightforward (Watson, 1999). Morse (1995) argues that many researchers claim to have reached theoretical saturation without actual proof

of this, as there are few guidelines that determine how to achieve saturation. Instead, the notion of *theoretical sufficiency* has been introduced by Dey (1999) who proposes that categories are not *saturated* from the data but rather are *suggested* by the data and that theories are susceptible to change and modifications, and thus not stable entities.

Nonetheless, GT is recognised as challenging the traditional dominance of quantitative research methods, and contributing over the years to legitimise the status of qualitative methods (Charmaz, 2006). Grounded theory has provided researchers with a rigorous method of enquiry, whilst at the same time remaining sensitive to participants' accounts, which the researcher found especially useful being a novice to qualitative methods.

6.7.2   Methodological limitations and recommendations for future research

There were a number of issues that can be perceived as limitations of this study. The sample size and characteristics of participants raise questions of transferability. Whilst the sample size (eight participants) may be considered small to be able to infer any generalisable finding, this was not the intention of this study. Rather, a qualitative approach with a small sample was used to obtain an in-depth understanding of the intricate and idiosyncratic meanings, experiences and views of PT for qualified counselling psychologists.

A further issue which can be considered as a limitation of this study is that the majority of the participants were female (2:6). However, the ratio in this study is a near representation of the percentages of male and female counselling psychologists in the population. The BPS (2007) published a study reviewing the demographic characteristics of applied psychologists that concluded the majority of psychologists are indeed female. Nevertheless, this is not to suggest that the gender of participants influenced the findings more than any other characteristic, such as socio-economic or ethnic-cultural background. Perhaps future research could include a more equally

balanced sample of female and male participants to determine if there are any differences in responses between the genders.

No study to date has investigated the role of therapy for counselling psychologists - and their views of this - in the context of CPD. The findings that have emerged from this study offer a useful base from which to build on to empirically explore this topic further. For instance, larger-scale surveys and quantitative methods could be used to explore and validate some of the factors identified in this study pertaining to attitudes and uptake of post-qualification PT. Similarly, additional qualitative research using purposive sampling (e.g., of more recently qualified counselling psychologists; of counselling psychologists working within the NHS and within private practice; of counselling psychologists working with specific therapeutic orientations) will provide alternative perspectives on PT post-qualification as a personal or professional activity.

A further detail that could be seen as a limitation of this study is present in the interview schedule. The use of the word "gained" in the interview schedule could have possibly biased participants' responses. Despite the potential of leading participants to only reveal positive aspect of therapy, many did report negative experiences and were able to speak openly about these in the interview when probed further. The use of a more neutral word, such as obtained, may have been better suited as perhaps more impartial.

6.8   Reflexive Summary

As Bannister et al. (1994) states, "reflexivity is about acknowledging the central position of the researcher in the construction of knowledge" (p. 151). Reflexivity fosters a critical attitude, with the researcher being aware of their role on the research design, data collection, analysis and the findings (Gough, 2003), and increases understanding of

both the phenomenon under study and the researcher's own assumptions and behaviours which may impact on the study (Watt, 2007).

To foster a reflexive attitude, I kept a research journal to help me continuously question my assumptions and presuppositions, and think about the ways in which my involvement may have influenced and informed the present study. Writing memos and keeping a self-reflective journal to record thoughts and hunches during the entire research project are techniques I found useful as they fostered a greater awareness of the assumptions, interpretations and biases I held.

As a trainee counselling psychologist, I was undoubtedly influenced by my own experience of PT but was also interested in exploring other counselling psychologists' views of this and whether they felt they gained anything from it personally and professionally. It is important to acknowledge my role as a counselling psychologist trainee interviewing qualified counselling psychologists and how this may have impacted upon the interview process, influencing participants' responses and shaping the interactions. My role as a trainee may have contributed towards equalling out at least some of the power imbalances that the researcher may have had over the participants by virtue of taking the role of the researcher. In addition, all of the participants were older than the researcher and most held more knowledge of this subject area. This could have perhaps rendered participants less nervous in the research process. Conversely, I am also aware that interviewing qualified practitioners may have resulted in them feeling restricted in speaking freely about their experiences of seeking therapy, preferring to maintain a professional stance with a trainee in their profession and avoid feeling scrutinised.

Further, my previous training also played a key role in shaping and forming my ontological and epistemological position. As an undergraduate student I was more familiar with quantitative research and positivistic notions of reality. Embarking upon

the counselling psychology training, with its emphasis on individual experiences, contributed to my increased appreciation for how individuals construct meanings through their social interactions.

Finally, this research experience overall has been of great significance for my personal and professional development, providing me with the unique opportunity to develop my identity as a researcher and practitioner. Further, through this research process I have grown to be more reflective and critical in my thinking and able to question the often cited claims of what is truth or reality, which is still very much an on-going process.

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Appendix A. Information for Potential Participants

I am a student at Roehampton University and am in my last year of the PsychD in Counselling Psychology. The research study that I will undertake will contribute to the completion of my professional doctorate.

It is widely assumed that personal therapy is one way of achieving self-development at the initial stages in counselling and psychotherapeutic training, however research exploring the role of personal therapy once qualification is attained has been sparse. There has been little detailed qualitative research in the UK on how counselling psychologists view or make use of personal therapy once qualified. This study will attempt to explore and provide an understanding of experienced counselling psychologists' perspectives of engaging in personal therapy since entering professional practice.

One-to-one interviews, lasting approximately one hour, will be conducted at a time and place that will be convenient to participants. Participants will be asked open-ended questions during the interview process which will allow for reflection and self-exploration. The interview process will be kept open so participants are free to explore their experiences of personal therapy.

Inclusion criteria of participants is to be based on the following requirements; that they have completed an accredited training in Counselling Psychology, have been qualified for at least three years (preferably), have a minimum of three years post qualification clinical experience (preferably) and have experienced a minimum of forty hours of individual therapy as a part of their training.

If you are interested in this study and feel that you would like to participate or have any questions then please feel free to contact me:

Maura Abdelall

Email: abdelalm@roehampton.ac.uk
Tel: 07931229137

Thank you for your Interest

Appendix B. Participant Consent Form

It is assumed that personal therapy is one way of achieving self-development at the initial stages in counselling and psychotherapeutic training, however research exploring the role of personal therapy once qualification is attained has been sparse. There has been little detailed qualitative research in the UK on how counselling psychologists view or make use of personal therapy, both in training and once qualified. It is hoped that the proposed qualitative research will provide some insight to how personal therapy is experienced, understood and engaged by counselling psychologists since entering professional practice.

Semi-structured individual interviews will be conducted by the researcher, which should last approximately one hour, at a time and place that is convenient and safe for the participants. Participants will be asked open ended questions during the interview process which will allow for reflection and self-exploration. All interviews will be audio recorded and transcribed by the researcher.

Audio recordings and interview transcripts will be kept at all times in a safe place at the researcher's home. Extracts from the interview may appear in the researcher's doctoral thesis and in publications arising from it, but any identifying details will be removed. The recorded data may be heard by a supervisor and others who may be involved in the examination of the thesis. Any documents with identifying details will not be available to view by anyone other than the researcher.

Everything disclosed will be treated confidentially, however there is a limit to this: if a risk of serious harm to yourself or others is disclosed the researcher may need to take appropriate action in accordance with the ethical guidelines of the British Psychological Society. You are free to withdraw from the research at any point and the data will be subsequently destroyed.

I look forward to your contribution and thank you for your availability and commitment to participate in this study.

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name ………………………………….

Signature ………………………………

Date ……………………………………

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Appendix C. Briefing Information Form

Thank you for your participation in this study.

Data gathered during this interview process will be held securely and anonymously. Personal information or identifying details in transcribed interviews will be removed or altered to protect participant's identity.

If for any reason you wish to withdraw from the study, then please contact the researcher with your participant number (above) and all data and documentation relating to you will be deleted or destroyed.

Should you have any concerns about any aspect of your participation or have any other queries then please do not hesitate to raise this with the researcher. However if you would like to contact an independent party please contact Director of Studies and/or Head of Department.

Investigator Contact Details: Maura Abdelall: Psychology Department, Roehampton University. Email: abdelalm@roehampton.ac.uk

Director of Studies Contact Details: Dr. Anne-Marie Salm: Psychology Department, Roehampton University, Whitelands College, Holybourne Avenue, London, SW15 4JD. Email: A.Salm@roehampton.ac.uk

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Research Supervisor Contact Details: Dr. Lyndsey Moon: Psychology Department, Roehampton University, Whitelands College, Holybourne Avenue, London, SW15 4JD. Email: Lyndsey.Moon@roehampton.ac.uk.

Appendix D. Interview Schedule

The first 5 questions were presented to all participants, the subsequent 3 were asked to 3 participants willing to elaborate further on emergent themes.

1- What are your views of personal therapy for qualified counselling psychologists?

2- What is your experience of personal therapy as a training requirement?

3- Have you engaged in personal therapy since training? If yes, could you tell me what it was that prompted you? What did you hope to achieve?

4- How has your experience of personal therapy been? What did you gain from it personally and in relation to your work with clients?

5- How likely are you to seek personal therapy in the future? If you have not sought it so far, under which circumstances would you consider it and what would you hope to gain from it?

Additional Questions:

1- How was your experience of personal therapy during training?

2- Did your experience of personal therapy during training influence you later seeking it?

3- How can personal therapy be better integrated into training programmes?

Appendix E. Demographic Questionnaire

The information collected below will be anonymous and not linked with any interviews transcripts or any other forms of data provided by you in this research. Please tick or circle your selected answer.

Age:

Gender: Male   Female   Other   Not Stated

Ethnicity

White	**Mixed**
☐ White British	☐ White and Black Caribbean
☐ White Irish	☐ White and Black African
☐ Any other white background	☐ White and Asian
	☐ Any other Mixed background

Asian or Asian British	**Black or Black British**
☐ Indian	☐ Caribbean
☐ Pakistani	☐ African
☐ Bangladeshi	☐ Any other Black background

Chinese or other ethnic group	
☐ Chinese	☐ **Not stated**
☐ Any other ethnic group	

Year of Qualification:

Years of Clinical Experience:

Theoretical Orientation: Humanistic
                                Psychodynamic
                                Psychoanalytic
                                CBT
                                Other (please specify: ....

Profession: Clinical Practitioner
                                Consultant
                                Academic
                                Other (please specify): ....

Employment Site: Private Practice
                                NHS- Hospitals/GP
                                University
                                Other (please specify): ....

Experience of personal therapy post-training: Yes   No

Length of personal therapy experience post-training:

Appendix F. Description of Participants

Pseudonyms have been used to protect participants identifying details and to maintain confidentiality.

1- **Bob:** Is a 61 year old white English disabled male. He qualified in 1997 completing a master in counselling psychology and has 15 years of clinical experience. He explained that he has engaged on and off in personal therapy for the past 15 years. He is currently working in private practice as an integrative practitioner. He lives in an affluent area of London and can be considered from a middle-class socioeconomic status.
His view of personal therapy as a training requirement was most favourable, as well as seeing it as a component of CPD. He seemed to value the therapeutic relationship amongst the many things gained through therapy. First experience of personal therapy explained as being a 'torture'.

2- **Joanne:** Is a 62 year old white female, mother and wife. She qualified in 2007 and has 11 years of clinical experience. She engaged in personal therapy during her 4 year training and approximately 2 ½ years post- qualification. Jo had also received short-term therapy as part of her recovery from breast cancer. Her experience of therapy once qualified was through the NHS and some short-term CBT.
She is currently working in private practice as an integrative practitioner.
She expressed financial reasons and prioritising family needs would   make seeking therapy difficult. She was in favour of personal therapy during training and also as part of CPD and valued much the benefits encouraging family members to also seek therapy when   needed.

3- **Patsy:** Is a 45 year old Asian mother. She qualified in 2010 and has 17 years of clinical experience. She engaged in therapy during training and had also been engaged in personal therapy 3 years post-training. At present she is employed part-time in the NHS and part- time in her private practice, in an affluent area of London.
She revealed that personal therapy was not integrated into training and that it felt like a 'box-ticking exercise'. She expressed that if needed she would engage in personal therapy, however she felt that building a stronger relationship with her partner reduced her need to have the support of personal therapy. It had been 9 years since she was in therapy.

4- **Kate:** Is a 65 year old female, mother and grandmother. She qualified in 1995 and has 21 years of clinical experience. She completed a master in counselling psychology and experienced personal therapy throughout the 5 year part-time course. She revealed that since post-training she has not engaged in personal therapy. Currently she is working as a consultant in the NHS and in private practice as an integrative practitioner.

She described her experience of personal therapy as 'something on   had to do' and that it was not properly integrated into the course.   She went on to say that despite her negative experience she was in favour of personal therapy as being a training requirement for counselling psychology, but with more information being provided. She also expressed being in favour of making personal therapy a component of CPD.

5- **Dave:** Is a 39 year old male working in private practice in a very affluent area of London. He qualified in 2002 and has 10 years of clinical experience. He experienced 4 years of personal therapy during training. Post-qualification he had engaged in personal therapy for approximately 2 years.

6- **Susan:** Is a 46 year old female, single mother. She qualified in 2006 and has 10 years of clinical experience. She engaged in personal therapy for approximately 3 years during her training but had not sought therapy since. She is currently employed in the NHS in London and has recently started her private practice as an integrative practitioner.
She viewed personal therapy as a valuable tool to resource oneself but she had found peer support as a way to make up for the loss of therapy. The flexibility of the course was something highlighted as being important, especially for a single mother. It was difficult but possible to work, to study and be a mother.

7- **Jan:** Is a 50 year old white female. She qualified in 2001 and has 11 years of clinical experience. She experienced 7 years of personal therapy during her training and approximately 7 months of therapy post-qualification. She is currently employed in the NHS in London and considers herself as practicing from a humanistic and CBT perspective.

8- **Della:** Is a 60 year old white female. She qualified in 2009 and has more than 30 years of clinical experience. She experienced 2 years of personal therapy as part of her training. Since training she has engaged in 10 sessions of therapy. Currently she is employed in the NHS and is practising pastoral counselling in private practice.
She revealed that her experience of personal therapy was somewhat   negative. She expressed viewing personal therapy necessary during training, but that post training it should not be as one is supposed to   have had enough self-exploration. She also stated that too much therapy then becomes .narcissistic'. Competence and orientation of therapist were key components to consider when seeking a therapist.

Appendix G. Illustration of a Coded Interview Transcript

Interview Transcript	Coding
Interviewer- So I'm going to be asking you a couple of questions about personal therapy. Some of the questions may seem overlapping...so just answer them as you can. First question is what are your views of personal therapy for qualified counselling psychologists?	
Kate- (laughs) urm...I think it's a really good idea and I think it should be encouraged but from a personal perspective I've been very remiss. I haven't really since my training completed I haven't had any personal therapy at all.	Favoring therapy post-training

Not engaging in therapy post-training |
| Interviewer- Mmm | |
| Kate- But, I think it's probably something that should be...maybe it should even be part of CPD maybe it should be something that, you know, you actually do...maybe there should be a number of hours maybe that you do minimally of personal therapy every...I don't know every 5 years or something. | Personal therapy as part of CPD development

Engaging in personal therapy at different points in life/career |
R- Mmm. And did you have that during your training?	
P- In my training I had personal therapy...I had personal therapy really for about 5 years.	Disclosing amount of personal therapy during training
R- Ok..during the training?	
P- during the postgraduate training.	
R- And that was a mandatory requirement was it? Or was it something	

you engaged in cos you wanted?	
P- Oh no no no it was a requirement. I wouldn't have...err...I mean I might have done. But no no no it was definitely a requirement.	Engaging in compulsory therapy, ambivalence about it
R- So since post qualification you say you haven't engaged in personal therapy?	
P- No post..my...actually I qualified with my masters in '93 or '94 but I didn't get the chartered status until '95, that was from the BPS, because you had to...you actually have to *then* you had to go through quite a procedure with the BPS for them to grant you chartered status because I was...i think I might have been one of the first chartered psychologists to get chartered status actually. Because it was such a new urm...because counselling psychology was so new then.	Not engaging in personal therapy post-training Attaining chartered status Being one of the first chartered counselling psychologists
R- So the 5 years would you say they were sort of intermittent or was it consecutive?	
P-No it was consecutive one after the other. And the personal therapy I think 1 year I had about 25 hours and then another year I think I had about 15 hours.	Having consecutive but different therapists
R- And was it from different orientations or...	
P- It was, it's strange and it sounds quite dreadful actually but in those days urm the orientations weren't so clearly defined. Where I did my postgraduate which was at Roehampton, where you are, urm there was no CBT training at all...not even any mention of it.	No clear distinction between therapeutic orientation Lack of integration of other theoretical orientations in training
R- Mmm mm	

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	Prevailing person- centered and psychodynamic approaches.
P- Urm everything was really psychodynamic or I suppose person centred but particularly psychodynamic really and so any personal therapy that I had was probably all psychodynamic really. Because there wouldn't even have been...wouldn't of even crossed my mind to look for somebody for CBT or integrative or existential or anything like that.	Engaging mainly in psychodynamic therapy
R- So it was the predominant.	
P- It was the predominant thing, the whole department was very psychodynamic the whole thing was really psychodynamic and so when you got your own therapy it was psychodynamic.	Feeling psychodynamic to be of overall importance and predominant approach in training
R- Yes, ok. Urm and how was your experience of personal therapy of personal therapy during your training and as a training requirement really.	
P- Urm...I didn't really enjoy it. Urm... and I think that was probably because I am not very good at self disclosing. Probably one of the reasons that I went on to do the postgraduate work and to do this work now is because it's much easier to listen to other people's stuff, but it is really acknowledge your own I think...and I'm sure that the idea is you have your own therapy in order to help you understand and have insight into yourself so that you can then sort of deal with all of that in the countertransference and all the rest of it and the parallel process that goes on. Urm but I think from a personal point of view I think that because I was so busy doing the course and doing all the work really engaging in the personal therapy, as maybe you	Not enjoying personal therapy in training Difficulty in self-disclosing Easier to listen to others problems than one's own Using therapy as a way to understand oneself better and the countertransference phenomenon Demands of training course Personal therapy during training as a secondary thing

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should have done, was rather secondary. So I was kind of doing it because you had to. But I wasn't necessarily thinking aha, you know, this is a great personal journey this is a great personal growth experience.	Not experiencing value of personal therapy
R- Did you feel it imposed in a way? Or that you felt that it was too intrusive?	Finding therapy intrusive when training
P- I think it was both. I think I found it...intrusive..I mean you're using the right word *now*. I don't think I found it intrusive at the time. I think I just wasn't ready at that time in my life to go into my own stuff and a part of that was because I am not a very good self discloser anyway and the other side of it is I think that the demands of the training was so big that there was little time left for myself really and also I got children and, you know, home to run and all of those things and I suppose having to rush off to personal therapy as well as all the other things was quite sort of tiring really.	Not comfortable at self-disclosing Demands of training, life interfere Difficulty in slotting in personal therapy in life
R- Did you find a difference maybe between therapists or did you feel that generally that was how you felt?	Finding a difference between therapists
P- No there was quite a difference in therapists. There was one man that I saw who was Greek and he was a psychiatrist. Urm and I found it...actually at the time I found it very very distressing really, but now I look back, you know 20 odd years or whatever or more down the line, I realise that actually if I had been more open to it and probably had more experience really it was quite insightful. I think probably what... I could have gained a lot from that. Because he was sort of a dominant bullying sort of man very fond of himself	Seeing a psychiatrist during training was an insightful experience. Fearing self-disclosure

and, in terms of the transference and everything, he was definitely my father or somebody like that. So looking back now it was very useful but at the time I didn't like it at all.	Therapist as father figure Not realizing therapy was helpful at the time
R- Ok. And the next question would be more how likely would you seek personal therapy in future and if you have not looked for it so far under which circumstances would you consider it and what would you hope to gain from it?	
P- Well I would consider it, I think now. I think nearly 5 years ago my sister died, she was considerably younger than me. And at the time I was working in a big private consultancy up in central London and I had a lot of very good work there and urm and it was a good place to be and it paid very well, but then when my sister died I got shingles and really in retrospect, but it's always easier to in hindsight, I think probably then to have maybe asked somebody there to give me some sessions of personal therapy would have been very helpful in terms of dealing with all of that sort of bereavement stuff and also the work. But I didn't... and urm I sort of... well I didn't really do anything really. I just had shingles and then I just said to them that I was going to take some time off which they gave me and then I never went back again. I told them that I didn't want to go back that I was tired. I was tired because the work was quite intensive and urm...but I think that's something that now I regret. I think I could have used that far more there.	Considering seeking personal therapy in future for the death of a loved one working in a high powered environment as a consultant Seeking therapy in hindsight, for bereavement experienced not seeking help or support psychosomatic symptoms developing taking time off resigning from position due to burnout regretting not seeking therapy
R- So in a way you're saying if there was something major like a loss or bereavement you would consider therapy	Emphasizing therapy as a support for

in future?	therapists
P- Oh definitely, definitely. In fact I would go as far as to say that you would, you can't legislate obviously for that, but I think you could emphasise it far more. I think that's the one thing in this work that you don't realise probably how debilitating it is. I think if there's a loss, death whatever, I think that there is a sort of...well I just don't think you realise just how emotionally debilitating it is and so therefore...it's not that you're going to be a harm to your clients, or your patients if you call them that, it's not that you're going to be doing them any harm or anything like that but I think it's more self- care. I think it's more your own care, so it would be therapy not so much because it's important for the well- being of your clients it's more for you. It's more for the actual therapist I think.	Not realizing difficult life issues can be debilitating

Therapy as a self-care activity for emotionally demanding role |
R- Sort of to prevent maybe burn out or..	Personal therapy as burn-out prevention and well-being of the therapist
P- I think so because I was just hugely fatigued, exhausted, drained...	
R- Do you know why you didn't seek therapy at that time? If you think back?	
P- Yes, I think it was probably because the environment that I was working in was a private high- powered environment and even though, it's ridiculous really because they were very supportive of me, I at the time didn't feel that I could sort of be, what's the word, lesser than 100% pretty much in such a high- powered environment, very busy environment.	Pressures of work
Working in high powered environment

Shame in feeling vulnerable- not the perfect therapist |
| R- Mmm, so in a way because you have worked in a consultancy level there may be this expectation of you to always keep it together in a sense and maybe... | Embodying a powerful position |

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P- I think that's absolutely true. I think that maybe if I'd been, because I was also sitting on some board I can't remember what it was called- the clinical advisory committee- all sorts of things and I think that there's something isn't there...it's interesting as I'm saying this to you as you get higher up in an organisation or whatever, then the less easy it is actually to then say look I'm struggling I could do with some help. Whereas if you're lower down then it's easier.	Difficulty in disclosing vulnerability due to high-powered role Being in lower position it's easier to disclose or show vulnerability
R- And has something ever happened with other colleagues that maybe you felt, you know, other colleagues not being very understanding towards somebody seeking therapy or their views or is it something that comes from within? .	Not supported by colleagues during difficulty
P- Urm going back to where I was in central London I think I was a little bit resentful that people weren't more empathic and coming forward offering...because I think if I'd been in..if there'd been a similar...cos I supervise people there too and there are a couple of people I supervise and I know that if they'd been going a loss or a bereavement I know that I would have been much more supportive to them. But where I was coming from urm I didn't feel that I had that kind of support really. Not that they were not supportive but not they were supportive either. It's hard to sort of explain really...	Not feeling supported as she would have been with others in same position
R- Sort of neutral maybe. P- But they certainly weren't as supportive and offering of advice in that way as much as I would have been.	No support or advice offered by organization of work during difficulty for therapists

	Feeling resentful
R- Right.	
P- So that made me feel rather resentful.	
R- And do you feel that some of that may sort of stop you today if you think ok do I want therapy or not do you think about what, you know, maybe thought about this? Somebody in a consultancy position maybe should not? Or even the type of therapists you find are you looking for different standards because it's a different type of relationship when one is qualified looking for a therapist it's a bit different to when you're a student.	
P- Oh hugely, oh God absolutely.	
R- So something's like that would stop you from seeking therapy?	
P- Oh God I mean hugely. That actually is, as you're saying, I'm just realising that is a huge thing for me is competency in others, trust in others. Well not so much trust, not trust I think I would pretty much trust somebody to be sort of trying to do their best or whatever, but its competency and that's a big thing I think. That's a big thing for me really. I would find it (laughs) I would probably find it quite difficult to find somebody, actually as I'm saying it probably where I was, at this other big place, there weren't many people who I would have really felt were competent anyway, actually in a way.	Seeking competent and trusting therapist
	Competency is more important
	Difficulty in finding a competent therapist
	Not feeling that many therapists are competent
R- Do you think that's maybe, you know, one of the reasons that would make it difficult to sort of engage in therapy to actually spur you on and say ok I'm going to look for a therapist?	Selecting a therapist a big process
P- Now yes, now definitely. Now it	Looking for the perfect therapist

Transcript	Code
would be a big selection process yes. I'm not saying I wouldn't find anybody off course I would if I really started looking but it would be, obviously, very very exacting...I'm not saying I'm great but, you know, but because of my experience and everything obviously one becomes quite fussy (laughs).	Becoming selective of therapist
R- Mmm. And do you think there would be an issue about also maybe, you know, the financial side because it is costly? Do you think there would be something like that that would keep you from seeking therapy do you think?	Finances an issue when seeking therapy during training
P- Urm well it might do urm (exhales) goodness that's really hard to say really. Urm I mean I would have sort of a cut off point probably of how much I'd be prepared to pay.	Finances not currently an issue
R- Right, but so far this isn't one of the reasons that has held you back?	Financial burden during training of supervision
P- No oh no, no no. I mean it might have held me back in the past when my children were younger and things like that but now not so much because I'm not so sort of pushed for money really now as I was. But it would have been, off course it would have been cos you had to pay for your supervision which has to be you have to have your supervision. So, personal therapy comes very low really on your list...and certainly yes cost wise supervision is more important so shelling out, you know, supervision and personal therapy is quite expensive.	Personal therapy becomes low priority Supervision more costly and more important
R- Urm yes, so in a way it sounds like at the moment or since training you haven't sought personal therapy because you haven't felt the need for it? Or maybe in hindsight there would have been a	Seeking therapy during a bereavement

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situation...	
P- Yes that situation with my sister dying. Yes, but I definitely think that I should have done. But then i...but then I think, you know, that would have been...ideally I would have wanted that in-house, rather than having to go and seek it.	Wanting in-house/compulsory therapy at work
R- Why is that do you think?	
P- Urm that's a good question really, Urm maybe it's something to do with me having some notion some idealised notion that if you work as a psychologist in an organisation, it could be the NHS it could be a smaller place, where I was was quite small, urm that there is on offer in-house therapy for somebody who is- going back to this thing about if anybody's had a loss or a bereavement that they should be automatically in a sense be offered that. Urm and I think that, you know, even if one pays for it there's something about that I think. There's something about....	Providing therapy in workplaces for employed psychologists Offering in-house therapy for bereavement or loss
R- So the work environment should provide that?	
P- Yes I think it should when you do this kind of work.	
R- But if it doesn't would you sort of not seek it elsewhere? You would rather have it in-house as opposed to...	Providing therapy in-houses forces one to have therapy
P- I think I would rather have it in-house because I think then it forces you in a way. The supervision that I do at Bupa, the psychologists and counsellors there they have to have supervision. They're forced to have, or they have to have supervision in order to work for BUPA.	Encouraging in house therapy as in house supervision on work site

But I think that they're also in a department whereby something did happen to one of them which was sort of maybe, you know, put them on a bit of a vulnerable position I think that they would be encouraged to have their own maybe in- house therapy maybe they'd come and see me or somebody like me, you know, without the supervisors hat on but with a sort of therapist hat on. So a lot more awareness.	
R- I'm just sort...so you said that therapy during training wasn't great or you didn't have such a positive experience or you didn't appreciate it at that time with everything going on and I'm wondering has that contributed to your view of how you see it now? Has that come in...because I'm also thinking about the reasons you may not have gone back to it.	
P- I think...i think probably...	
R- Or do you find other ways to get sort of support other than personal therapy?	Personal therapy for personal growth
P- Well I think that...i think the difference probably, the difference as you're asking that question I'm thinking that when I was training the personal therapy was intended to be sort of personal growth really. And when we sort of fast forward to when I regret not actually really actively engaging in it was when there was a crisis and I think there is a difference between personal growth therapy and crisis therapy and I..oh gosh this is going to sound dreadful now, but I think that there's something in it for me personally I'm sure other people would disagree or whatever, is that I still feel that there's something self indulgent about therapy for personal growth and I	Regretting not actively engaging in this when in crisis

Difference between personal therapy for personal growth and personal crisis

Finding personal therapy as self-indulgent

Being more interested in crisis than |

think it's probably also influenced my work really, the work that I find myself doing, I don't have so much interest I think in personal growth work as I do in crisis work and I think that that applies to me too. That I struggle, would struggle, to go and get therapy when it's just to do with growth, personal stuff...journey all of that. But like when my sister died, when there was a crisis when there was something genuinely in that time troubling then... R- So, only when there's something quite significant and that's difficult in your life would you seek personal therapy or crisis therapy? P- Except I realised, you now, that's not rational, because off course personal growth all of that is important but that's just my view. R- Yes your view of personal therapy. So I'm wondering how that translates maybe in the client work...have you found any difference when you were in therapy with your clients and maybe not now and if that has changed in any way or not? P- Well I think it certainly I mean I always knew that bereavement and loss, I mean all of us know that really so fundamental to training, you know that bereavement and loss is so profound you know in terms of people seeking therapy. But I think the one thing it did highlight for me was the psychosomatic side of things I think. You know the fact that I had a huge loss and a sort of a trauma and a crisis, because she died in a particularly awful way, urm that it was my body my body. I worked for a year and then my body developed shingles.	personal growth Struggling to have therapy for personal growth Preferring to seek therapy when in crisis Acknowledging irrationality of own statement Acknowledging importance of personal growth Knowledge of bereavement and loss through training Impact of stress on health Experiencing a huge and traumatic loss Developing psychosomatic symptoms-shingles

R- So you didn't deal with that you just continued to work?	Continuing to work regardless if ill health
	Learning from experience
P- I just continued to work and I think that was something that...it was a huge it was a really big learning curve for me in terms of doing this work. In a sense, you know, when you're with a client if they have a great loss or something like that you know that that's going to precipitate all sorts of things for them.	Clients' stories of loss evoke personal experiences
R- Yes so I'm wondering how you deal with that? When a client sort of brings in something which triggers something in you how do you sort of deal with it?	Experiencing parallel process with clients
P- Urm yes it's funny, I mean I haven't really had any particular...i mean there have been yes obviously clients, you know, the parallel process going on whereby there's something going on in the client's life which sort of then makes me think of, you know, what happened with my sister. But to be honest I come from such a dysfunctional background, family wise, that most clients would probably have something that there will be a parallel process going on to be honest, even before my sister died. Which is why I have always thought that most of the people who do this work eventually, come from that kind of background. I actually don't see how anybody who doesn't come from quite a troubled and dysfunctional background could really do this work anyway (laughs). So so not specifically with that death no, but with all sorts of other things yes.	Revoking thoughts of death of sister
	Having a dysfunctional family
	Most clients issues reflect personal issues
	Having a difficult upbringing part of each therapist, the 'wounded healer'
R- And would that be something you would sort of process by yourself or would you get peer support or would you go to supervision as opposed to therapy?	

Would these be some of the other things you would engage in? P- I think I'd probably go to supervision. I'd probably...there's a little bit of a a a crisscross or a a a blurring I think, for me, between supervision and personal therapy. Urm that's true and I think that's also sometimes how I can be in supervision sometimes depending...there's a bit of a blur. But, and I'm not blowing my own trumpet at all here- it isn't really a blowing trumpet but I think it's just to do with how you are and the years that I've worked now, is that I am very self analytical and I will sit down and, you know and have done in the past, almost formulations and things like that about my own life as I would for clients. You know I sort of been practising or I thought well I'll do this or I'll try that and I will always been the first person I do it on. So that is something I do quite effortlessly really. R- Now I am kind of zooming out and looking at personal therapy in a larger perspective in terms of...obviously for training it's required and after training it's not necessarily required and it's not even part of continuing professional development. I'm wondering what your views are on that? P- Well I think it should be. I think it probably should be, although that sounds rather kind of...I don't know that sounds rather sort of...a bit too kind of compulsory. I mean cost, as you said cost, time all kinds of things. There are enough time constraints on people who do this work anyway and off course supervision is such a hugely important thing. Urm it's hard really, urm I don't know really, I think I said at the	Going to supervision for support Blurring between roles of therapy and supervision Working for many years in the field Being self-analytical/self-reflective Making up own formulations practicing a different way of thinking Favoring personal therapy as part of CPD Cost, time and supervision factors which impinge seeking therapy Personal therapy as CPD Engaging in therapy at different intervals

beginning didn't I that it should maybe be something like CPD. Maybe there should be something about every 5 years...maybe every 5 years or something you should do 10 hours of personal therapy rather than doing the usual continuing professional development. Maybe that would be something, because I do think yes I mean it would be interesting now...I'm trying to think now, you know, as we speak what issues I would be looking at in my own therapy now. And I suppose there's a bit of a concern in me thinking about it that in my time of life there's masses really...I mean I could go on and on having personal therapy now until I died. Because you could really, because once you get into personal growth you could just go on and on and on couldn't you, really?	Having minimum hours set as part of CPD Thinking of issues to take to therapy Having therapy indefinitely personal growth as a continuous factor
R- So I guess the question is so what stops you? What would stop a person?	financial concerns of engaging in therapy
P- Well there would be an element of money because obviously, you know, I don't know 60-70 pounds a week or whatever a week, a month I'd be thinking to myself well I could take my grandchildren here or I could do...do you know what I mean? I'd be thinking that all the time and then there's this element of self indulgence, I'd be thinking for God's sake!	preferring to use money in alternative ways with family members therapy as self-indulgent
R- So I'm wondering if that also reflects a bit like the idea that, or maybe you were made to feel like that, when you're in a high position you almost have to deal with it yourself and the self indulgent thing comes there...can't I get on with it alone?	Unacknowledged issues within
P- I think so...i mean it could well be. I	Loss of sister

mean I haven't actually acknowledged to myself, you know, because there's been all sorts of bits and pieces going on recently nothing as dreadful as my sister dying but bits and pieces. I mean my mother's got dementia my father's got lung cancer there's all sorts of other things so, you know, there's masses of things that I could talk about and go through and I could and maybe it would be lovely (laughs) it would be really nice, but I can't easily do it. I can't somehow...i can't really reconcile such a large amount of...and as I'm saying it to you I'm thinking probably maybe I don't also want to get dependent on it. I think again I do think money does come into it because I've got this fantasy that probably it would be a minimum of 50 say and so probably once a week and so you're talking about a couple of hundred or whatever a month...erm and then I'm sort of thinking umm oh goodness, you know, what could I do with that for sort of myself or family or whatever and then I'd be thinking oh I could get almost addicted to it I've got to keep doing it...and then we're talking about thousands and then I'm suddenly thinking how...and then I would become angry then and I'd be thinking ahh it's ridiculous.	parents deteriorating health many things one could explore in therapy seeing therapy as a nice thing, but unable to engage in not wanting to be dependant on therapy fantasy of therapy being expensive using money for family becoming addicted to therapy expense of therapy causes anger finding it ridiculous
R- So do you feel it's not money thrown away but money you could use to do something else?	alternative methods of self-care
P- Yes. Even like go to a mindfulness retreat or things that are rather more soothing. Rather more soothing I think, yes like that. I'm still flabbergasted that some clients would choose to spend their 60 odd quid or whatever or sometimes a bit more with me than maybe go and have a lovely massage (laughs) or	Not understanding why clients spend much on therapy preferring a massage

something.	
R- mmm, so in a way you're saying what you would get from personal therapy could be achieved in other ways...in some sense?	Resistant to becoming emotionally dependant
P- Yes, yes and again as I'm saying this to you I'm thinking that maybe...maybe what I'm quite resistant to is becoming emotionally dependant on somebody and then becoming emotionally dependant on them and then resenting how much it's costing me. So maybe it's better to just go and do something like a massage, a retreat or something like that's sort of indulgent but very...sort of you're not going to become dependent on it, they're one off's really and you're in control.	Resenting the cost and becoming dependant in someone else Becoming less dependent on a retreat or a massage
R- Right, so if you decide even with a therapist I'll have 10 sessions do you feel you could become dependent in those 10 sessions or do you feel 10 sessions wouldn't be enough anyway?	Viewing short term therapy as superficial, not sufficient
P- Absoultely10 sessions wouldn't be... it would just be the tip of the iceberg...not even the tip of the iceberg. It would be actually as I'm saying that to you I think that's a big thing for me. Again, you know, you get to my age and all the rest of it there's so much that I could probably, you know...	
R- So I a way you're saying it's either long term therapy or it's best to just not to go there because...	Long-term therapy has more depth
P- Yes. Yes. I think so absolutely and off course once you get into the long-term therapy department or area, whatever you want to call it, maybe you're talking about twice a week. Maybe...in other words you're talking about something	

rather more than just coming along to, you know, counselling or whatever on a weekly basis or a fortnightly basis, you know, you're talking about something...it would have to be a very serious undertaking for me now, and it probably would go on maybe for years.	Long-term therapy a serious undertaking
R- And you said you recognise, with your sister, in hindsight you could have done a bit of therapy and you said a bit about having some difficulties now, has it ever crossed your mind I'll go and speak to somebody or again it's just head down and get on with it and maybe feel it somatically?	Getting on with things
P- Mmm, head down I think get on with it and if I begin to feel a bit sort of down physically or whatever as I said I'd rather spend that money, you know, go off and have a week in Tunisia with and pay for all other people to come with me...do you know what I mean? Than spend that, whatever it is, on this twice a week intensive long term therapy.	When feeling down spending money on holidays with other people
R- and also zooming out quickly even more I guess just sort of generally counselling psychology as a profession the majority is women, usually middle class, white...do you have any ideas about what that might be due to or maybe one of the reasons maybe you yourself engaged in that profession?	Starting training as a mature student
P- Well I engaged in it because I was a mature student anyway in my thirties, because when I left school I was a bit of a ....i wanted to work and so I worked for a bit, then I went to art school. I did all sorts of funny kind of things, messing around really. Then after a divorce I went to do my bachelors and did the psychology and it wasn't until I'd done	

that that I kind of even thought about what I'd do post-graduately. I mean there could have been all sorts I could have done educational, occupational whatever... but urm counselling psychology was new and I just kind of...I was a mature student, there was a little clutch of us a little band of us mature students and we just thought that's what we'll do. And because it was so new there was a diploma in it and so a little group of about 4 of us did the diploma and I just sort of fell into it that way and strangely I think that if I could have waved a wand, again its hindsight really, I think what I would have done after the diploma was I think I should have gone to somewhere like Goldsmiths and done an arts therapy masters because I'd already got an art degree. And I'm...that's a big interest of mine really, but I didn't and I stayed with the counselling psychology.

R- Why was that?

P- Urm...i don't know really...i don't know really. I think probably because I was with this little group of 4 women and we were friendly and Goldsmiths is quite a long way you'd had to have had a big portfolio of work and, you know what it's like, once you get into a university and you're doing one thing after another you kind of get swept along really. I mean I could still... I could have done an art therapy thing, I could do it now if I wanted to.

R- But also I'm wondering in terms of actually then employment, I'm wondering if there's sort of a connection there between a lot of women going into counselling psychology, which then is an employment which that can work part | Counselling psychology a new profession

Peer influences in choices made

Contemplating other trainings

Peer group influence |

time and have children...	Doing training due to money from divorce
P- Yes, yes going back coming back to your question I could never have done this training, any of it, if I hadn't been divorced, because by being divorced urm I had a lump of money at my disposal which allowed me to do it and then I...this sounds dreadful (laughs) but I was divorced again and I had some more money. You know I mean it sounds as if I...you know it wasn't like I was rolling around in money at all, you know, I wasn't but I did have enough at least to pay the fees and off course, you know, when you're a woman and you've got kids university study is quite appealing because it means that you can work it round your kids so that's quite useful...so urm. But I mean I could never ever...I mean I don't know how anybody could do this training anyway if they're not middle class, in the sense that they've got somebody who's bank rolling them. I don't know how you could do it?	Divorcing once more and receiving money
	Paying fees with divorce money
	Demands of children and studying
	Flexibility of course
	Training done by middle class individuals
	Additional costs of the course
R- It's very expensive.	
P-...because you've got your supervision, you've got your own therapy, you've got transportation hither and yon and heavens I'm sure the fees since I did it have probably quadrupled. Probably more than quadrupled. And your books and oh God it's just like endless. Somebody has got to bank roll you really and it's all very well, I mean people who are doing clinical psychology as a postgraduate that was paid for by the NHS then, I don't know if it is now. But in those days you'd go straight out from your bachelors you'd get into the NHS and you'd do your clinical training all paid for.	Needing financial support to do the training

R- And that wasn't something that you looked into?	
P- I don't know why I didn't do clinical, I could have done. I don't know why.	
R- I'm just wondering if some of your decisions may have been around also well once I qualify this will allow me to work the hours I want around my kids?	Influence of motherhood on choice in training
P- Yes I think it did. I think maybe yes I think probably again if I'd been a childless person straight out of university or something like a lot of them where who went into clinical then maybe I would have done. Actually I would have been more likely to have gone to Goldsmiths and done the art therapy really. And I think, as I'm saying that to you, I think that probably is linked to my own therapy actually. Coming back to this thing about my therapy is I think that there are things that, for me, would be more easily expressed urm in art work, in images than using language.	Doing alternative course Expressing emotions more easily through art therapy
R- Right, was that something that you also found in your therapy?	
P- Yes I think so. I think when I said to you I'm not a natural discloser I think, even though I'm a great talker and I can sort of, you know, I went into advertising when I left school so I can probably talk talk talk...but I think when it comes to self disclosing I think I would be probably better in images.	Good at talking but not self-disclosing
R- So I'm wondering actually how tough it must have been for 5 years to be in that process of needing to disclose yourself to a therapist and maybe the fact that it was imposed because you had to tick off the hours.	Resenting compulsory therapy

P- Yes, oh no absolutely. I think I probably did resent it if I think about it and I did sometimes rock up, not late exactly but really not ready to be engaged. Just there, you know, just there.	
R- Do you think you can remember like any positives that you could have taken away or do you think there so many negatives that outweighed the positives?	Valuing positives of therapy in hindsight
P- well I think that any positives I got are purely in hindsight now as I look back that the Greek psychiatrist guy who I think was absolutely such a great sort of replica of my father I think or would have been hugely useful if only I'd stuck at it or taken it more seriously. The other ones that I saw to be honest I just thought they were just irritating, middle class, women who'd (laughs) who'd just irritated me and I just sort of did it because I had to do it but...	Finding some therapists as irritating Sticking with unhelpful therapy experience for the course requirements
R- So how come with the Greek psychiatrist it came to an end? Did you end it?	Therapy ending due to therapist leaving the country
P- Urm he I think left the country. I think I saw him for about 18 months and then he left the country. He was a Freudian and he had a picture of Freud, well not a picture a little bust of Freud on the table in front of us and I think that's why I say to you now that if I was going to do it it would have to be psychoanalysis and it would probably have to be something like twice a week...or not at all.	Going back to therapy if psychoanalysis
R- Yes, something quite deep.	Engaging in long-term psychoanalysis for personal development, not crisis
P- Yes...or not at all. Certainly from the personal development side of things, again that's different to your crisis, which is a different thing.	

Appendix H. Ethics Approval

Ethics Application Ref: PSYC 11/ 023

Jan Harrison
|
To: Maura Abdelall;
Cc: Lance Slade; Diane Bray; Anne-Marie Salm;
...
Wed 07/09/2011 12:52 PM
You replied on 07/09/2011 10:40 PM.

Dear Maura,

<u>Ethics Application</u>
Applicant: **Maura Abdelall**
Title: **Experienced Counselling Psychologists' Perspectives of Engaging in Personal Therapy after Qualification**
Reference: **PSYC 11/ 023**
Department: **Psychology**

I have just received the revised version of your application form, with section 9 completed by your Director of Studies as requested.

As all the other conditions were minor and it is assumed that you will adhere to these and therefore did not require a response, I am pleased to confirm that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Regards

Jan

Jan Harrison
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